DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
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IN REPLY REFER TO
BUMEDINST 6320.66C
BUMED-32
14 Feb 2001

BUMED INSTRUCTION 6320.66C

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Medical Department Personnel

Subj: CREDENTIALS REVIEW AND PRIVILEGING PROGRAM

Ref: (a) DoD Directive 6025.13 of 20 Jul 95
(b) JCAHO Accreditation Manual for Hospitals
(c) JCAHO Accreditation Manual for Ambulatory Care
(d) BUMEDINST 6320.67A
(e) SECNAVINST 6401.2A
(f) SECNAVINST 5212.5D
(g) BUMEDINST 6010.13
(h) SECNAVINST 1920.6B
(i) CPI 752 (NOTAL)
(j) OPNAVINST 6400.1B
(k) DoD Directive 6040.37 of 9 Jul 96
(l) SECNAVINST 5720.42F
(m) SECNAVINST 5211.5D
(n) SECNAVINST 1120.6B (NOTAL)
(o) SECNAVINST 1120.8B (NOTAL)
(p) SECNAVINST 1120.12A (NOTAL)
(q) SECNAVINST 1120.13A
(r) BUMEDINST 7042.1
(s) SECNAVINST 5214.2B
(t) BUMEDINST 6300.8
(u) DoD Directive 5154.24 of 28 Oct 96 (NOTAL)
(v) BUMEDINST 6000.2D
(w) BUMEDINST 6010.17A
(x) U.S. Navy Diving Manual, volume I
(y) U.S. Navy Diving Manual, volume II
(z) CDC MMWR 40(RR08); 1-9; July 12, 1991

1. Purpose. To reissue policy and procedures for a Credentials Review and Privileging Program for Department of the Navy (DON) fixed and nonfixed medical and dental treatment facilities (MTFs and DTFs), per references (a) through (c) and as part of the DON clinical quality management program. Adverse privileging actions, monitoring, and reporting of practitioner or clinical support staff misconduct and due process (fair hearings and appeals) are in reference (d). References (e) through (y) provide additional guidance. This is a complete revision and must be read in its entirety.

2. Cancellation. BUMEDINST 6320.66B.

3. Quality

a. A Navy Medical Department quality goal is "best value" in health care. Best value is defined as the highest quality of health care services delivered in a timely and economical manner. We will achieve best value through implementation of best clinical business practices.

b. Each element of best value is a result or outcome that must be measured and documented to quantify our performance and assess the effectiveness of improvement activities. Achieving best value demonstrates the Navy Medical Department is a competitive member of the health care industry and thus becomes invaluable to our patients, other customers, and stakeholders.

c. This instruction supports this system quality goal by:

(1) Ensuring the people who deliver health care in our system are properly trained, competent, and able to provide high quality health care services.

(2) Ensuring we have robust provider competency management processes in place and under continuous improvement.

4. Background. Under reference (a):

a. The Assistant Secretary of the Navy (ASN(M&RA)):

(1) Has policy oversight of the Military Health System (MHS) Clinical Quality Management Program (CQMP) within DON.

(2) Recommends changes in the MHS CQMP to the Secretary of Defense through the Assistant Secretary of Defense for Health Affairs (ASD(HA)).

(3) Ensures the Chief, Bureau of Medicine and Surgery (BUMED) complies fully with references (a), (k), and (u). Ensures the Marine Corps establishes the key elements of a CQMP for those operational air, ground, and fleet clinics not accredited by a nationally recognized body like the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

b. Health care provider credentials and privileging activities are a subset of the CQMP.

c. Department of Defense (DoD) directives, instructions, and memoranda can be found electronically on the internet at: http://web7.whs.osd.mil/corres.htm. Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) policy documents can be found at: http://www.tricare.osd.mil/policy/plcydocs.html.

5. Applicability. This instruction applies to all military (active duty and Reserve) and civilian health care practitioners and clinical support staff (as defined in section 5), who are assigned to, employed by, contracted to, or under partnership agreement with DON activities or who are enrolled in a Navy-sponsored training program.

6. Authority to Grant Professional Staff Appointments with Clinical Privileges. As required by JCAHO standards, the Chief, BUMED serves as the governing body and is designated the corporate privileging authority for all DON practitioners. The following are designated representatives of the Chief, BUMED and are authorized to grant professional staff appointments with clinical privileges:

a. The designated privileging authority for practitioners assigned to fixed MTFs or DTFs is the commanding officer (CO) of the treatment facility. The Assistant Chief for Health Care Operations (MED-03) and the Assistant Chief for Dentistry (MED-06) are designated as the privileging authorities for practitioners who are COs of fixed MTFs and DTFs, dental battalions (DENBN), and U.S. Navy dental commands (USNDC) respectively. CO privilege request packages are forwarded to the Naval Healthcare Support Office (HLTHCARE SUPPO) Jacksonville, FL for processing.

b. The designated privileging authority for practitioners assigned to the fleet, excluding the Fleet Marine Force (FMF), is the fleet type commander or fleet dental officer for dentists or echelon equivalent.

c. The designated privileging authority for practitioners assigned directly to Headquarters, U.S. Marine Corps (HQMC); Commander, U.S. Marine Corps Forces Pacific (MARFORPAC) Headquarters; Commander, U.S. Marine Corps Forces Atlantic (MARFORLANT) Headquarters; or, I, II, III Marine Expeditionary Forces (MEF) Headquarters, is the Assistant Chief for Health Care Operations (MED-03) and the Assistant Chief for Dentistry (MED-06). Marine Corps practitioners at the headquarters level,

requesting privileges at a treatment facility, shall use the professional affairs department in that treatment facility for request coordination. Privilege request packages are forwarded to HLTHCARE SUPPO Jacksonville, FL for processing.

d. The designated privileging authority for practitioners assigned to non-FMF Marine Corps units is the commander or MEF commander exercising authority over the unit to which the practitioner is assigned.

e. The designated privileging authority for all practitioners, except dentists, assigned to a Marine Division (MARDIV), Marine Air Wing (MAW), or Force Service Support Group (FSSG), including the Functional Area Code (U) (FAC (U)) health care provider, is the commanding general at MARFORLANT or MARFORPAC. The technical and administrative support for their subordinate commands may be consolidated at either the MEF or the subordinate command level.

f. The designated privileging authority for dental officers assigned to the FMF is the CO of the DENBN/USNDC to which the dental officer is assigned.

g. The designated privileging authority for practitioners assigned to nonclinical billets, who are authorized by their CO to seek a staff appointment with clinical privileges in a MTF or DTF, is the CO of the MTF or DTF where such health care services are performed.

h. The designated privileging authority for practitioner researchers when practice is limited to a research organization is the CO of the specific research organization. The Director of Research and Development (MED-26) is the privileging authority for practitioner researchers whose commands do not possess the privileging process elements and cannot fulfill the criteria specified in this instruction.

i. The designated privileging authority for inactive Naval Reserve practitioners is the Officer in Charge (OIC), HLTHCARE SUPPO Jacksonville, FL, shown in section 4, paragraph 3.

j. The designated privileging authority for practitioners assigned to Naval Operational Medicine Institute is the CO.

k. Flag and general officer privileging authorities may delegate privileging signature authority to their chief of staff. Requests for any other delegation of privileging signature authority will be considered to mitigate unusual circumstances. Send requests to MED-03 or MED-06 via OIC, HLTHCARE SUPPO Jacksonville, FL.

7. Confidentiality

a. All personnel shall comply with reference (k).

b. Credentials and privileging files may appropriately contain documents that are not medical quality assurance records such as criminal investigative reports, indictments, court-martial records, or nonjudicial punishment records. When considering written requests from regulatory or licensing agencies for copies of records that contain such documents, the procedures in reference (m) must be followed to determine the records are releasable.

c. In all disclosures, care must be taken to protect the privacy interests of other providers and the patient following the procedures in reference (l).

d. Requests by regulatory or licensing agencies for information regarding permanent adverse privileging actions or reportable misconduct must be referred to MED-OOL (legal).

8. Responsibilities

a. The Chief, BUMED, under the Chief of Naval Operations, is responsible for technical professional evaluation and execution of the credentials review and privileging program within the guidelines of this instruction. BUMED shall:

(1) Ensure certifications of professional qualifications required by references (n) through (q) are based on verified credentials documents, so identified in the individual credentials file (ICF) and individual professional file (IPF).

(2) Establish, in coordination with chiefs of the appropriate corps and the specialty leaders, standardized clinical privilege sheets which prescribe both core and supplemental privileges reflecting currently recognized scopes of care for each health care specialty.

(3) Ensure privileging authorities, when granting clinical privileges, confirm the practitioners requesting clinical privileges possess the required qualifying credentials and are currently competent to provide the privileges granted.

(4) Ensure commands that lack either adequate numbers of assigned professional staff or the expertise within the command to meet the requirements of this instruction receive the technical support and assistance necessary for compliance.

b. The Commander, Navy Recruiting Command, per reference (a), shall ensure the requirements of this instruction are met by all commands under his or her cognizance.

c. The Commander, Naval Reserve Force, per reference (a), shall ensure the requirements of this instruction are met by drilling health care providers in the Selected Reserve and the Individual Ready Reserve (IRR).

d. Commanders and COs of MTFs, DTFs, and naval medical research and development organizations, per reference (a), are responsible for carrying out the requirements of this instruction.

9. Fees. Responsibility for fees associated with obtaining and maintaining basic qualifying licenses or certifications lie with the practitioner. Appropriated funds may be used to pay fees, in advance, for required verifications per reference (r). Title 10, United States Code, section 1096, states that when it is necessary for a member of the uniformed services to pay a professional license fee imposed by a government to provide health care services at a facility of a civilian health care provider under an external partnership agreement, the Secretary of Defense may reimburse the member for up to $500 of the amount of the license fee paid by the member.

10. Policy. The DON recognizes quality of health care services and depends on the coordinated performance of clinical and administrative processes. Total quality management in the Navy Medical Department is the primary means for ensuring health care quality. The potential consequences of unqualified or impaired health care providers or provider misconduct are so significant that complete verification of credentials and adequate control of clinical privileges is imperative. Licensure, certification, or registration is a qualification for employment and commission as a

uniformed health care provider in the military health care system and is required throughout the period of employment and commission irrespective of assignment, billet type, or duties and responsibilities, e.g., clinical, research, executive medicine, or business administration. Since licensure, certification, or registration is an employment and commission qualification requirement; this requirement remains in effect even if the individual moves from direct patient care into a nonclinical assignment or duties. DoD policy, reference (a), states all licensed, independent health care practitioners shall be subject to credentials review and shall be granted a professional staff appointment with delineated clinical privileges by a designated privileging authority before providing care independently. Practitioners must possess a current, valid, unrestricted license, certificate, or exemption or be specifically authorized to practice independently without a license, certificate, or exemption, per reference (e), to be eligible for a professional staff appointment with clinical privileges.

a. Privileging authorities must measure and periodically assess (at intervals not to exceed 2 years) the clinical performance and conduct of all assigned health care providers following this instruction.

b. Privileging authorities must maintain an ICF on all health care practitioners, whether holding a staff appointment with privileges, practicing under a plan of supervision, or enrolled in full-time inservice training, and an IPF on all clinical support staff per this instruction. Additionally, COs of fixed MTFs and DTFs must maintain ICFs and IPFs on health care providers who are assigned to other activities in which there is no designated privileging authority, as designated by the Chief, BUMED. Disposition of ICFs and IPFs shall follow reference (f) and this instruction. COs must ensure information contained in the ICFs and IPFs is monitored, continually updated, and reported to the DON Centralized Credentials Quality Assurance System (CCQAS) quarterly, by the first workday of each quarter.

c. Privileging authorities must maintain a mechanism, separate and distinct from the ICF, containing practitioner specific information generated through the organization's quality management activities. This data must include reflected workload (productivity), peer review, outcome indicators, and medical staff quality management activities. The performance

appraisal report (PAR), appendix A, for all health care practitioners providing direct patient care services, shall be generated based on this information.

d. Privileging authorities must grant clinical privileges to health care practitioners using standardized, specialty specific privilege sheets contained in this instruction. These privilege sheets reflect the currently recognized scope of care appropriate to each health care specialty. COs must ensure health care practitioners provide services and treatments consistent with their approved clinical privileges.

e. Eligible health care practitioners are required, upon reporting for clinical duty, to request a professional staff appointment and the broadest scope of core and supplemental privileges commensurate with their level of professional qualification, current competence, and the ability of the facility to support the privileges requested. Physicians assigned as COs or executive officers, whose credentials and current competence support, may apply for primary care medical officer privileges regardless of prior privileges held. Such application offers maximum flexibility for COs and executive officers who wish to maintain clinical experience while fulfilling their primary duties. Eligible health care practitioners may hold more than one set of privileges if they meet the above requirements. Those who do not maintain required qualifications or do not request such privileges are subject to processing for separation for cause under reference (h) for military personnel, or for administrative action including termination of employment under reference (i) for civilian employees. COs must ensure practitioners conform to this guidance and must initiate the required administrative action in a timely manner if they fail to do so. COs must provide practitioners the resources and training necessary to meet their prescribed responsibilities.

f. COs must assign clinical support staff clinical responsibilities commensurate with their health status, licensure or certification, education and training, and current competence. Clinical support staff who do not maintain required qualifications or current competence are subject to processing for separation for cause under reference (h) for military personnel, or for administrative action including termination of employment per reference (i) for civilian employees.

g. Interns may not be granted clinical privileges during their internship. Health care practitioners enrolled in residency or fellowship training programs may not be granted clinical privileges in their training specialty, but may apply for and be granted clinical privileges in a health care specialty for which they are already fully qualified. Granting staff appointments with clinical privileges to residents and fellows should be the exception rather than the rule, should impact upon the training program as little as possible, and should only be considered when the purpose is to maintain clinical competence in operational medicine privileges or to meet an operational mission-essential requirement as determined by the operational unit commander. DON treatment facilities may employ and grant staff appointments with clinical privileges to civilian practitioners who are currently enrolled in graduate medical education (GME) programs only if the practitioner meets all the following criteria:

(1) They have completed all the clinical requirements of their current program.

(2) Their current training program responsibilities are limited to research activities.

(3) They are seeking employment to maintain their clinical skills.

(4) They have the written approval of their training program director to be employed.

h. COs must assign nontrainee practitioners, who are required to practice under supervision because they fail to qualify for clinical privileges, duties commensurate with their health status, licensure or certification, education and training, and current competence.

i. Those practitioners who do not qualify for clinical privileges within 1 year may be processed for separation for cause under reference (h) for military personnel, or for administrative action including termination of employment under reference (i) for civilian employees, or under the terms of their contract or agreement for contract or partnership practitioners.

j. Health care practitioners who have a potentially infectious disease or who are undergoing treatment or evaluation for a temporary medical condition that may impact their ability to provide safe patient care, and the condition does not require a medical board, will be temporarily reassigned to nondirect patient care activities. This administrative reassignment is not an adverse action.

(1) The limitation of privileges of a practitioner infected with the human immunodeficiency virus (HIV), solely based upon a risk of disease transmission to a patient, is considered administrative and is not an adverse privileging action. (Example: An HIV-infected surgeon who is outwardly healthy, but who is restricted from performing exposure prone invasive surgical procedures due to a risk of provider-to-patient HIV transmission.)

(2) The limitation or revocation of privileges of a practitioner infected with the HIV virus as a result of medical impairment caused by acquired immune deficiency syndrome (AIDS) is considered an adverse privileging action. (Example: An HIV-infected provider who has become physically debilitated by AIDS to the point he or she can no longer practice.)

k. Before allowing a practitioner infected with the HIV virus, or similar life-threatening infectious disease, to perform an exposure prone invasive procedure, a privileging authority must evaluate each individual case using current Centers for Disease Control guidelines as contained in reference (z). At a minimum, an expert review panel should advise the privileging authority about what circumstances, if any, the provider might continue to perform exposure prone invasive procedures. Such circumstances would include notifying prospective patients of the practitioner's seropositive status before they undergo exposure prone invasive procedures.

l. Health care providers whose professional impairment or misconduct may adversely affect their ability to provide safe, quality patient care must be immediately removed from direct patient care activities under the provisions of reference (d). This is not only a regulatory requirement, but also a moral and ethical responsibility of the officials involved.

m. Impaired providers, as defined in section 5, paragraph 2, must have their clinical practice reviewed by the executive committee of the medical staff (ECOMS), executive committee of the dental staff (ECODS), or directorate, as applicable.

n. Personnel who by skill designation or job classification and current competence are qualified to provide health care services, but who are not health care providers as defined in section 5, are not authorized to provide care independently, except for independent duty corpsmen providing care under reference (j), diving officers, master divers, diving supervisors, and deep sea diving medical technicians per references (x) and (y). The above are not eligible to participate in the privileging process, but may provide services only under supervision.

o. COs must investigate, without delay, allegations of health care provider impairment (physical, mental, or professional), misconduct, substandard performance, or moral or professional dereliction, including reportable misconduct, per references (a) and (d).

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Available at:
http//navymedicine.med.navy.mil/instructions/external/external.htm

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SECTION 1

ROLES AND RESPONSIBILITIES

1. General. The corporate responsibility of the Chief, BUMED to establish direction for the DON multi-institutional system in maintaining an effective credentials review and privileging program is consistent with the responsibilities exercised by civilian health care governing bodies. The COs of MTFs and DTFs, fleet type commands (TYCOMs), and FMF commanders serve as extensions of BUMED functioning as regional governing bodies for facilities under their cognizance.

2. JCAHO Requirements. This instruction complies with the governing body and medical staff standards of references (b) and (c).

3. Credentials Review and Privileging Program. All DON organizations providing health care shall establish a credentials review and privileging program per this instruction.

4. Commanders in Chief, TYCOMs, Commanders, COs

a. Privileging authorities and senior medical department representatives, per reference (a), shall exercise the necessary controls considered prudent and reasonable to ensure:

(1) Health care practitioners are appropriately granted staff appointments with clinical privileges.

(2) The quality of health care provided by privileged practitioners and clinical support staff is measured, assessed, and improved.

(3) Health care practitioners practice within the scope of their approved clinical privileges.

(4) Nonprivileged practitioners and clinical support staff are qualified to perform assigned duties.

(5) Nonprivileged practitioners are appropriately supervised.

(6) Establish mechanisms to ensure all health care providers meet the licensure, certification or registration requirement irrespective of assignment, billet type or duties and responsibilities.

b. While it is of utmost importance to comply with the guidance in this instruction, the role of the commander or CO is to use the requirements of this program to accomplish the DON mission of providing high quality health care. If good judgement dictates deviation from this instruction, the following guidance is offered:

(1) Be aware of the deviation.

(2) Have a sound, supportable reason for the deviation.

(3) Document the rationale.

(4) Ensure the quality of care delivered to the patient is not compromised.

(5) Notify MED-03 (clinical management) of the deviation and any other unintended policy effect that constrains the overall mission.

5. The Assistant Chief for Health Care Operations (MED-03)

a. Has responsibility for administration and technical oversight of the credentials review and privileging program.

b. Serves as the privileging authority for practitioners who are COs of fixed MTFs and HQMC practitioners.

c. Provides coordinating action to HLTHCARE SUPPO Jacksonville on staff appointments with clinical privileges for Medical Corps officers who are COs of fixed MTF/DTFs.

6. The Assistant Chief for Health Care Operations (Clinical Management)

a. Develops and maintains instructions implementing the DON credentials review and privileging program.

b. Provides policy support and assistance regarding credentials review and privileging.

c. Maintains liaison with external agencies, including DoD, other services, and civilian bodies.

d. Assigns MTFs and DTFs ICF and IPF maintenance responsibilities for health care providers assigned to activities without professional affairs support capability, or outside the DON.

e. Assigns fixed MTFs and DTFs to provide technical assistance for commands without adequate medical or dental staff available to advise the privileging authority.

7. The Assistant Chief for Education, Training, and Personnel (MED-05)

a. Ensures the completeness of the credentials information required, as listed in appendix B, by the Commander, Navy Recruiting Command.

b. Ensures pre-established professional competency criteria are developed for and used by the applicable professional review board in the selection of new accessions as required by references (n) through (q).

8. The Assistant Chief for Dentistry (MED-06)

a. Serves as the privileging authority for practitioners who are COs of fixed DTFs, DENBNs, and USNDCs.

b. Provides coordinating action to HLTHCARE SUPPO Jacksonville on staff appointments with clinical privileges for Dental Corps officers who are COs of fixed MTF/DTFs.

9. Assistant Chief for Reserve Force Integration (MED-07). Provides coordinating action between HLTHCARE SUPPO Jacksonville and the Centralized Credentials Review and Privileging Detachment (CCPD) for inactive naval Reserves assigned to perform active duty for special work (ADSW) to provide health care services. When orders are cut, the CCPD shall forward a CTB to the gaining command informing MED-07 under separate cover (message, fax, e-mail, or speed letter).

10. The Staff Judge Advocate to the Chief, BUMED (MED-OOL)

a. Provides oversight and guidance on medico-legal aspects of the credentials review and privileging program with an emphasis on adverse privileging actions per reference (d).

b. Develops and maintains instructions implementing the DON program for monitoring and reporting adverse privileging actions, incidents of reportable misconduct, and separation or termination of employment due to disability of health care providers.

11. Office of the Medical Inspector General (MED-00IG). Provides oversight of the credentials review and privileging program, identifies areas that need policy development and identifies undesirable or unintended policy constraints through the inspection process.

12. Fleet Commanders in Chief. Per reference (a) and in conjunction with this instruction, ensure compliance with the credentials review and privileging program by their subordinate commands; and, are hereby authorized to consolidate the technical and administrative support for their subordinate commands at this level. Fleet commanders in chief may elect to have a fleet-wide coordinated credentials review and privileging program to meet operational needs.

13. Fleet TYCOMs, Commander MARFORPAC, and Commander MARFORLANT. Per reference (a) conjoined with this instruction, serve as the privileging authority for health care practitioners assigned to commands under their cognizance and ensure compliance with the credentials review and privileging program by their subordinate commands. They may consolidate the credentials and privileging program technical and administrative support for their subordinate commands and delegate privileging signature authority at either the MEF or other general officer command level.

a. Ensure compliance with the credentials review and privileging program by all subordinate commands.

b. Aid effective implementation through education and technical assistance.

14. HLTHCARE SUPPO Jacksonville. As the only centralized credentials review and privileging activity for all DON health care providers, is the privileging authority for the Selected Reserves, and maintains Reserve ICFs and IPFs.

a. Coordinates and monitors implementation of the Centralized Credentials Review and Clinical Privileging Program and associated processes for licensed or certified active duty, Selected Reserve, and civilian health care providers within the Navy Medical Department.

b. Provides technical support on credentials review and privileging matters.

c. Implements and maintains the CCQAS database of DON health care providers.

d. Completes National Practitioner Data Bank (NPDB) query on appropriate practitioners upon accession, at the 2-year reappointment, or more frequently if indicated.

e. Is the caretaker of ICFs or IPFs of providers transferring to nonclinical billets or administrative duties when their CO is not a privileging authority and they are not going to request privileges locally.

f. Provides coordination and training for professional affairs coordinators to include assistance and guidance associated with the use of current and future program procedures and technology.

g. Maintains liaison with external agencies, including DoD, other services, and civilian institutions regarding credentials and privileging program process issues.

h. Monitors and reports on the medical readiness for all DON active duty and Selected Reserves through the CCQAS database.

15. COs of Fixed Treatment Facilities or other Authorized Claimancy 18 Activities

a. Serve as the privileging authority for health care practitioners under their cognizance.

b. Issue local implementing directives. Branch facilities are not expected to have a separate credentials review and privileging program, but are to participate in the parent command's program. A sample format is included as appendix C.

c. Establish mechanisms to ensure individual practitioners function within the scope of clinical privileges granted.

16. COs of the Various Naval Medical Research and Development Laboratories

a. Serve as the privileging authorities for practitioner researchers when practice is limited to the research organization.

b. Establish a credentials review and clinical privileging process per reference (a).

17. The ECOMS and ECODS are required by references (b), (c), (g), and (w) for medical and dental commands, respectively. All other privileging authorities must also provide a mechanism for medical or dental staff involvement in the credentials review and privileging process. This function shall be performed by an ECOMS or ECODS, as applicable, appointed by the privileging authorities designated in paragraph 6 of the basic instruction from among the privileged licensed independent practitioners under their cognizance.

a. If the professional staff includes nonphysicians or nondentists, representation on the committee from among these practitioners is recommended when matters concerning their peers are under consideration.

b. The chairperson must be a senior member of the professional staff.

c. For small commands, including the operational forces, the professional staff as a whole may serve as and fulfill the functions of the ECOMS and ECODS. This instruction recognizes clearly there are alternative methods of organizing management of operational medical departments to meet operational constraints.

d. Committee membership includes representation from branch clinics and clinical directorates, as applicable and feasible.

e. The ECOMS or ECODS:

(1) Oversees the credentials review and privileging process.

(2) Reviews and endorses applications for professional staff membership with clinical privileges.

(3) Considers input from all sources, including peer review, concerning the appropriateness of clinical privileges requested by health care practitioners.

(4) Recommends to the privileging authority specialty and facility specific criteria for staff appointments with clinical privileges.

(5) Documents committee actions by preparing and retaining minutes that include, but are not limited to:

(a) Convening of meetings.

(b) Meeting attendance.

(c) Recommendations regarding credentials review and privileging actions and justification for same.

(d) Rationale to support recommendations regarding deviations from this instruction as addressed in paragraph 4 of this section.

(6) Oversees the completion and submission of appendix A.

(7) Seeks amplification, clarification, and makes recommendations to the privileging authority regarding practitioner professional performance when there is reason to believe the practitioner is not performing within their delineated clinical privileges; not abiding by the policies, procedures and bylaws per reference (w); not practicing within acceptable standards of care.

(8) Ensures professional staff monitoring is performed following references (a), (b), (c), and (g).

(9) Assists in developing, reviewing, and recommending actions on policies and procedures for providing health care services.

(10) Oversees clinical competence.

18. Credentials Committee. In facilities where workload dictates, the CO may delegate credentials review and privileging functions listed in paragraphs 17e(1) through (4) in this section to a separate credentials committee, to serve as a subcommittee of the ECOMS or ECODS. The ECOMS or ECODS retains responsibility for oversight and endorsement of the activities of the credentials committee. The credentials committee membership shall be as follows:

a. The chairperson is appointed by the privileging authority, chosen from among the membership of the ECOMS or ECODS.

b. Members are nominated by the ECOMS or ECODS and appointed by the privileging authority.

c. Only privileged licensed independent practitioners permanently assigned to the command shall be appointed with the following exception: Inactive naval Reserve and nonphysician and nondentist health care practitioners who have staff appointments at the command are eligible for appointment to the committee to assist in the credentials review and privileging process of their peers. Document all committee actions per paragraph 17e(5) in this section.

19. Professional Affairs Coordinators

a. Are assigned on a permanent or collateral duty basis depending on the workload of the facility.

b. As the technical experts on credentials and privileging issues, render administrative and clerical assistance to the ECOMS or ECODS and the credentials committee, as applicable. Advise the governing body and leadership on credentials and privileging matters. Large treatment facilities are expected to

augment the professional affairs coordinator (PAC) with clerical assistance, plus any professional staff support necessary to comply with program requirements.

c. Maintain ICFs and IPFs, program directives, instructions, forms, credentials committee minutes, and working papers.

d. Interface with outside agencies to obtain required reports, i.e., NPDB queries.

e. Assist in the preparation of committee minutes; processing of privilege and staff appointment application and notification letters and privilege reappraisal documents; verification of credentials information; maintenance of documentation of trends based on quality management activities; and preparation of the peer review panel and appeal process documents.

f. Ensure necessary correspondence, messages, and reports received and transmitted are complete, accurate, and meet the requirements of this instruction.

g. Maintain a tracking system for the internal processing of documents relating to credentials review, staff appointment, and clinical privileges status.

h. Assist in the preparation and annual review of facility specific departmental criteria with appropriate department heads, thus ensuring criteria are appropriate to support the granting of clinical privileges.

i. Submit required information to the HLTHCARE SUPPO Jacksonville.

j. Monitor and track licensure, certification, and registration status for all uniformed health care providers irrespective of assignment, billet type, or duties and responsibilities, e.g., clinical, research, executive medicine, or business administration.

20. Clinical Directors

a. Monitor the credentials review and privileging process within their directorates.

b. Assume department head credentials and privileging responsibilities when their department heads' staff appointments with delineated clinical privileges are being initially granted, renewed, or appraised.

21. Department Heads

a. Provide continuing surveillance of the professional performance, conduct, and health status of department staff members to ensure they provide health care services consistent with clinical privileges and responsibilities. They shall also ensure nonprivileged practitioners, clinical support staff, and other personnel providing health care services in the department are under appropriate clinical supervision.

b. Maintain copies of approved staff appointments with delineated clinical privileges on practitioners assigned to their departments. For nontrainee, nonprivileged practitioners practicing under supervision (i.e., clinical psychologists and social workers who have not fulfilled clinical hours required for degree), the plan of supervision shall be maintained in the department file as well as in the ICF.

c. Recommend departmental, specialty, and facility specific criteria for:

(1) Initial staff appointment with clinical privileges.

(2) Active staff appointment with clinical privileges.

(3) Active staff reappointment, affiliate, or temporary appointments with clinical privileges.

d. Make recommendations for staff appointment with delineated clinical privileges based on the applicant's professional qualifications (health status, current competence, verified licensure, education and training, and NPDB query).

e. Use practitioner-specific results of quality management and risk management monitoring activities when making recommendations for professional staff appointments with clinical privileges.

f. Monitor quality management, and medical staff activities for individuals assigned to their department, using information received from command's information management system, to complete appendix A, as described in section 2.

22. Individual Health Care Providers

a. Practitioners must initiate an application for membership to the professional staff and request the broadest scope of privileges commensurate with their professional qualifications, level of current competence, and the facilities ability to support them. Those who fail to maintain qualifications or do not request such privileges are subject to processing for separation for cause under reference (h) for military personnel, or for administrative action including termination of employment under reference (i) for civilian personnel.

b. Practitioners of the MTF or DTF must comply with applicable professional staff policies, procedures, and bylaws per reference (w).

c. Providers are responsible for ensuring the accuracy and currency of all credentials and privileging information reflected in his or her ICF or IPF; e.g., licensure status, board certification, and privilege status at other facilities.

d. Providers must immediately inform the holder of their ICF or IPF of any change in status of any professional qualification, including health status, which could impair their ability to provide safe, competent, authorized health care services.

e. Providers must perform health care services within the scope of either the privileges granted by the privileging authority, the assigned clinical responsibilities in the case of clinical support staff, or the written plan of supervision for those practitioners required to practice under supervision.

f. Providers must participate in professional education programs leading to improved clinical performance and contingency preparedness.

g. Providers must actively support and participate in the facility quality management activities.

SECTION 2

PROCEDURES AND REQUIREMENTS FOR AUTHORIZING, DEFINING, AND APPRAISING THE SCOPES OF CARE PROVIDED BY HEALTH CARE PRACTITIONERS

1. General. All health care provided by health care practitioners must be specifically authorized and periodically appraised following this section. COs must not permit practitioners to diagnose, initiate, alter, or terminate regimens of health care, independently or under supervision, except as provided for in this instruction.

a. The authority for practitioners to independently diagnose, initiate, alter, or terminate regimens of health care is conveyed only through the issuance of professional staff appointments, i.e., appointment or reappointment to the medical or dental staff. A professional staff appointment requires the practitioner to adhere to the professional staff policies, procedures, and bylaws of the facility, per reference (w), and the code of professional ethics of their profession. Professional staff appointments must be accompanied by delineated clinical privileges defining the scope and limits of practice authorized. The procedures and requirements of this section are intended to comply with the intent of the standards for professional staff appointments of the JCAHO, references (b) and (c).

(1) The privileged practitioners at an MTF or DTF constitute the professional staff and are defined as the medical or dental staff, respectively. Professional staff appointments will be referred to as medical staff appointments or dental staff appointments as applicable to the treatment facility; e.g., a dentist appointed to the professional staff of an MTF is granted a medical staff appointment.

(2) The medical or dental staff appointment type reflects the relationship of the provider to the medical or dental staff. A professional staff appointment may not be granted in the absence of the granting of clinical privileges.

(3) Professional staff appointments with clinical privileges may only be granted or renewed by the privileging authorities designated in this instruction. Privileging authorities will grant professional staff appointments with

clinical privileges to practitioners only after consideration of the practitioner's verified license status, current competence, professional education and training, past professional performance, ability to perform and results of the NPDB queries. Periods of clinical inactivity greater than 2 years constitute evidence of a lack of current competence unless information to the contrary is provided. The ability or capacity of the MTF or DTF to support the clinical privileges requested and the health care demands placed on the treatment facility must also be considered when granting or renewing professional staff appointments.

(4) Practitioner eligibility for professional staff appointment and reappointment with clinical privileges is based on the practitioner meeting predetermined department, specialty, and facility specific criteria developed by the department head, endorsed by the ECOMS or ECODS, and approved by the privileging authority.

(5) Professional staff appointments terminate upon the practitioner's detachment from the command incident to permanent change of station (PCS), release from active duty (RAD), termination of employment or contractual agreement, facility closure or retirement.

(6) Detailed procedures for adverse termination of professional staff appointments, suspension, denial, limitation, or revocation of clinical privileges due to substandard care or misconduct are described in reference (d).

(7) Care must be taken to ensure initial and active staff appointments are not allowed to lapse. Should this occur, the privileging authority must prepare a letter to the practitioner, with a copy filed in the ICF, addressing:

(a) Inclusive dates of the lapse.

(b) Administrative, nonadverse nature of the lapse. If the lapse is noted during application processing, address the lapse in the comment section of the privileging authority's endorsement on the application.

b. Health care provided by practitioners in full-time inservice training programs must be appropriately supervised.

The authorized scope of care for practitioners enrolled in inservice training programs must be defined for each trainee-year level by program directors at each MTF or DTF, using criteria endorsed by the executive committee for graduate medical education and approved by the CO. The criteria used must specifically address the treatment facility, training program, year level, scope of care, evaluation criteria, frequency of evaluations, and supervision of the practitioner trainees.

c. The provision of health care by nonprivileged, nontrainee practitioners must be authorized and defined by a command-approved plan of supervision, specific to the practitioner, that contains the following elements:

(1) Scope of care permitted.

(2) Level of supervision, as defined in section 5, to be imposed. The level of supervision imposed is the prerogative of the practitioner's CO or OIC, unless that authority is specifically delegated to the department head by the CO or OIC.

(3) Identification of supervisor.

(4) Evaluation criteria.

(5) Frequency of evaluations.

d. Practitioners who have been clinically inactive for more than 2 years are, in due consideration for patient safety, presumed not currently competent and must undergo a period of practice under supervision. Practice under the provisions of paragraph 1c above. A practitioner who has practiced under a plan of supervision, and otherwise meets the criteria for an active staff appointment, may be granted an active staff appointment without first receiving an initial staff appointment.

e. Once granted an initial, active, or affiliate staff appointment with clinical privileges by a privileging authority designated in this instruction, a practitioner is eligible to provide health care services at all other DON treatment facilities using the CTB. Compliance with this instruction results in each practitioner having a single privileging authority.

2. Clinical Privileges. Clinical privileges define the limits of patient care services a practitioner may render. Privileges may be granted with or without an accompanying appointment to the medical staff. Except as noted below, clinical privileges are delineated using the clinical privilege sheets in appendices E through H. Practitioners apply for privileges using the privilege sheets applicable to their basic specialty; e.g., neurosurgeons use the neurosurgery privilege sheets, general dentists use the general dentistry privilege sheets, and general surgeons use the general surgery privilege sheets. Practitioners who are fully trained in more than one specialty, e.g., subspecialists or dual-trained individuals, are eligible to apply for privileges using all applicable privilege sheets. Practitioners applying for privileges under a contract or partnership agreement, to perform health care services in only one department, are granted privileges consistent with their current competence, license status, education and training, ability to perform, the scope of care provided in the department, and the scope of care delineated in the contract or agreement. For example, a general surgeon also qualified as a primary care physician, who is contracted to perform health care services only in an emergency room, should seek and normally be granted primary care privileges only. Additional emergency medicine privileges, with current competency, can be either itemized or added as supplemental to the primary care core list.

a. The DoD has issued policy guidelines regarding privilege categories: Regular privileges-granting permission to independently provide medical care for a period not to exceed 24 months; temporary privileges-time limited, rare, granted for a pressing patient need; and, supervised privileges (plan of supervision) used to identify nonlicensed or noncertified providers who can not practice independently. Note: Command consultant privileges or consultant privileges are not granted within the DoD policy guidelines for medical staff appointments and privileges.

b. Each of the specialty-specific privilege sheets in appendices E through H contains two categories of privileges, core and supplemental.

(1) Core privileges are defined as those privileges which, as a group, constitute the expected baseline scope of care for a fully trained and currently competent practitioner of

a specific health care specialty. Core privileges must be applied for and granted as a single entity. Because core privileges constitute a representative baseline scope of care, not all privileges in the core are required or expected to be exercised at all times in every facility. Privileges per reference (b) and (c) must be relevant to a given facility. Privileging authorities must inform practitioners in a timely manner of any facility-specific policies or procedure restrictions which preclude providing the health care services defined by core privileges. These facility privilege restrictions (limitations) must be annotated by two asterisks (**) on the core privilege sheet. The asterisks denote the facility cannot support that skill. The core privilege sheets are not to be modified locally. Changes to the core privilege sheets can be made only by the Chief, BUMED, following review by the appropriate specialty advisor and chief of the appropriate corps. Criteria, including education and training requirements, for the granting of core privileges are contained in appendices E through H.

(2) Supplemental privileges are itemized, facility-specific privileges that are relevant to the specific health care specialty, but lie outside the core scope of care due to the level of risk, the requirement for unique facility support staff or equipment, or being too technically sophisticated or new to yet be included in the core scope of care. Supplemental privileges can be requested and granted on an item-by-item basis. The provider must write yes or no by each supplemental privilege on the privilege sheet using predetermined department, specialty-specific criteria. These criteria must be developed by the department, endorsed by the ECOMS or ECODS, and approved by the privileging authority. The supplemental privilege lists may be modified locally to reflect the scope of care the facility can support and expects to provide.

(3) In instances where the expected scope of care is very limited or significantly less than the full core privileges level, or when there is reason to believe the applicant for privileges may not be qualified for the full core, privileges applied for and granted may be delineated through the use of a locally-generated, itemized listing of diagnostic and treatment procedures. Such itemized privileges are not corporate in nature and thus are not transferable within the DON health care

system. The granting of staff appointments with itemized delineated privileges (less than the core privileges) should be a transitional procedure, except for positions or contracts that specifically call for very narrow scopes of care. The goal should be to grant core privileges to as many practitioners as possible, including, particularly, inactive naval Reservists whose current competence for core privileges may be determined solely through an assessment of quality management activities related to their civilian practice. Examples of situations where using itemized listings to delineate where clinical privileges may be appropriate include, but are not limited to:

(a) When practitioners, whose previous privileges were less than the core for their specialty, report for duty.

(b) When granting a practitioner a very limited scope of care; e.g., contract or civilian practitioners whose contracts or position descriptions define a scope of care significantly less than the applicable core.

(c) When privileging practitioners following a period of clinical inactivity greater than 2 years.

(d) When privileging foreign national local hire (FNLH) practitioners as described below.

c. FNLH practitioners may apply for and be granted medical or dental staff appointments with clinical privileges if they possess a current, valid, unrestricted license (or the equivalent) to practice their specialty granted by the country in which the MTF or DTF is located. The staff appointments with clinical privileges granted to FNLH practitioners are specific to the local granting facility and are not corporate in nature; i.e., they cannot be used to practice at other DON treatment facilities. This limitation is not intended to reflect adversely on the competency of FNLH practitioners; however, the requirements of the status of forces agreements preclude imposing additional privileging requirements on FNLH practitioners.

d. Canadian practitioners who have graduated from an accredited Canadian medical school, and hold a Licentiate of the Medical Council of Canada, are accepted as equivalent to the Accreditation Council for Graduate Medical Education (ACGME)

accredited graduate trained in a U.S. hospital. They may apply for and be granted core or supplemental privileges upon receipt of a State license.

e. Practitioners, to the degree permitted by their license, training, the law, or DON rules and regulations, are authorized and expected to render such care as is necessary to save the life or protect the welfare of individuals in an emergency situation. Accordingly, emergency privileges are automatically awarded to practitioners by virtue of their staff appointment, negating the need for individual or specific delineation of emergency privileges. The provision of this paragraph does not negate the requirement for practitioners assigned to provide emergency care services to hold appropriate clinical privileges or be appropriately supervised if practicing under supervision.

3. Application for Initial Appointment with Clinical Privileges. Whenever practitioners apply for a staff appointment with clinical privileges they must be briefed on the local credentials review and privileging program by the prospective department head. The PAC provides the applicant with a staff appointment and clinical privileges application package, including at a minimum, a personal and professional information sheet (PPIS), appendix J, an application for staff appointment with clinical privileges, appendix K, and the applicable privilege sheets. The applicant is provided copies of, or access to, and agrees in writing to abide by the local credentials review and privileging directive, the professional staff policies, procedures, and bylaws per reference (w), and if applicable, a code of ethics. The code of ethics may be included as a component of the staff policies and procedures. The applicant shall submit a signed statement pledging to ensure or provide for continuous care of his or her patients.

a. Applicants for initial staff appointment (their first application within the Navy health care system) must complete each section of the PPIS, appendix J, at the time of application. If a section is not applicable, enter N/A. The PPIS must identify the treatment facility and must be signed and dated by the practitioner.

b. Applicants request delineated clinical privileges using the applicable privilege sheets with the assistance of their department head; the department head shall be guided by the

predetermined specialty-specific criteria. Requested privileges, modified and granted to meet and conform to the specific health care delivery demands and capabilities of the facility, are not to be construed as adverse as defined in reference (d).

(1) For practitioners reporting from DON treatment facilities, the applicant's detaching PAR, appendix A, serves as a letter of reference from and evidence of demonstrated competence at the detaching treatment facility.

(2) For new accessions, recalls to active duty, inter-service transfers, Navy Active Duty Delay Specialists (NADDS), and Full-Time Outservice (FTOS) trainee practitioners, the application information is compared to the credentials information forwarded by BUMED.

(3) All Selected Reserve practitioners, including direct accessions, shall apply to the CCPD, HLTHCARE SUPPO Jacksonville for an initial staff appointment with clinical privileges.

(4) For civil service, contract, and partnership practitioners entering the DON system, the application information is compared to the complete, verified credentials information obtained for inclusion in the practitioner's ICF, before employment or contracting.

(5) Appendix O provides a sample format for requesting information required to ascertain the current competence of applicants from agencies or treatment facilities outside the DON system.

c. References (a) through (c) require the health status of applicants for staff appointments are considered at the time of appointment to determine if any contraindications exist. The department head must document the physical and mental health status of the applicant was considered during the application process as part of his or her endorsement for staff appointment.

d. The PAC and the department head compare the information provided through the application process with the applicant's ICF or the CTB, confirming the presence and verification of all required documentation. All documentation discrepancies require satisfactory resolution. If the applicant does not have a Navy

ICF, one must be generated per section 4. Health status consideration by the department head and other parties may be accomplished through a variety of means, including, but not limited to, review of:

(1) A statement from the applicant's physician or a report of a physical examination indicating the applicant is free of mental or physical impairments.

(2) The applicant's statements regarding health status on the application for privileges and the PPIS, including updates.

(3) The PARs from previous commands.

(4) Responses to requests for credentials and privileging information from institutions or agencies external to the current treatment facility.

4. Granting of Initial Staff Appointments. Practitioners applying for staff appointment and clinical privileges who are new to the Navy health care system or who, although clinically active elsewhere, have not held an active staff appointment, granted under the provisions of this instruction within the last 2 years, must first be granted an initial staff appointment. The initial staff appointment period is intended to provide an opportunity for the practitioner to demonstrate to the privileging authority an understanding of and compliance with the facility's policies, procedures, and bylaws per reference (w), and to demonstrate current clinical competence in the requested clinical privileges as compared against predetermined department- and facility-specific criteria. Practitioners who have been clinically inactive for more than 2 years are, in due consideration for patient safety, presumed not currently competent and must undergo a period of practice under supervision. Practice under supervision is to be guided by a written plan, described in paragraph 1 of section 2. A practitioner who has practiced under a plan of supervision, and otherwise meets the criteria for an active staff appointment, may be granted an active staff appointment without first receiving an initial staff appointment.

a. The privileging authority grants initial staff appointments with clinical privileges:

(1) After review of the applicant's credentials (professional education and training, license status and history, consideration of health status, NPDB query, and current clinical competence) has been completed. There will be credentials that cannot be primary source verified due to medical school closures, destruction of documents, etc. In these cases, every attempt must be made to primary source verify the credential. If unable to verify, a memo must be placed in the ICF, where the document is or would have been, with all appropriate information, i.e., person or organization contacted with their title, date, telephone number, why credential cannot be verified, and any additional information. At this point the ICF is considered complete, with regard to this information, and may be forwarded for action.

(2) After applicable department head endorsement of the practitioner's application for staff appointment with delineated clinical privileges, the privileging authority may require additional endorsements.

(3) For a period not to exceed 1 year.

(4) In writing. A sample format is provided in appendix K. The appointment is effected when the privileging authority checks the approval block and signs and dates the endorsement page of the application. A separate appointment letter is neither required nor recommended.

b. After the practitioner has been granted an appointment, upon receipt of orders indicating imminent deployment, the PAC shall prepare a CTB generated from the centralized computer database, and forward it to the contingency assignment. A copy of the current CTB shall be maintained in section 2 of the ICF.

c. The privileging authority must assign a proctor, usually the department head, to monitor the professional conduct and clinical performance of each practitioner with an initial staff appointment. The proctor assists the department head in the preparation of the PAR, appendix A, before the expiration of the initial staff appointment. The proctor's monitoring activities vary with the scope of privileges granted and may include, but are not limited to:

(1) Review of ongoing monitoring and evaluation activities conducted as part of the facility's quality management program.

(2) Additional record reviews above and beyond the scope of ongoing monitoring and evaluation activities.

(3) Direct or indirect observation.

d. When, as determined by the practitioner's department head, the provider has demonstrated clinical competence and compliance with the policies, procedures, and bylaws per reference (w), and has met the applicable criteria for staff appointment and clinical privileges, the department head forwards a completed, endorsed PAR. The PAR is forwarded with the application for active staff appointment with clinical privileges at least 60 days before the expiration of the initial staff appointment.

e. For practitioners not assigned, employed, or contracted to an MTF or DTF full-time, it may be difficult to satisfy the clinical workload criteria required to qualify for an active staff appointment. In cases where the practitioner is providing health care at civilian treatment facilities during the initial appointment period, it is both appropriate and recommended to solicit and consider clinical performance information from these other facilities in determining current clinical competence, using a format similar to appendix O.

f. The practitioner is not required to complete the entire initial appointment period if demonstrated competence justifies an earlier active staff appointment. The practitioner, in consultation with the department head, must submit an application for active staff appointment, appendix K, when the criteria for clinical privileging and active staff appointment are met.

g. The initial staff appointment period is a period of independent practice, not a period of practice under supervision. However, the degree and intensity of surveillance, monitoring, and oversight required during the initial (provisional) appointment period is required to ensure patient safety while evaluating the practitioner's current clinical

competence. Activities designed to ensure patient safety while evaluating the practitioner's competence are not to be construed as adverse privilege actions.

5. Granting of Active Staff Appointments

a. Active staff appointments are granted under any one of three circumstances:

(1) After an initial appointment period, requiring endorsement by at least the department head, ECOMS or ECODS, and the privileging authority.

(2) After a period of practice under a plan of supervision during which all of the pre-established criteria for an initial staff appointment have been met.

(3) Upon reporting to a new assignment after having held an active staff appointment within the previous 2 years at another Navy medical or dental treatment facility, requiring the endorsement of only the department head and the privileging authority. The local privileging authority may impose additional endorsement requirements.

b. The privileging authority must grant an active staff appointment with delineated clinical privileges:

(1) Upon receipt of the practitioner's application for an active staff appointment.

(2) Following a review of the ICF to determine current clinical competence, demonstrated within the preceding 2 years, supported by practitioner-specific data and information generated by organizational quality management activities during the initial staff appointment.

(3) Following an interview with the practitioner, by the department head, to discuss the applicant's qualifications; local policies and procedures; the applicant's requested privileges; any facility limited privileges; and, the ability to perform requested privileges (health status).

(4) Following a review of the endorsements on the practitioner's application by the department head, directorate

(if applicable), credentials committee (if applicable), and ECOMS or ECODS, using the appropriate endorsement page in appendix K.

(5) In writing. Appendix K is a sample format. The appointment is effected when the privileging authority checks the approval block and signs and dates the endorsement page of the application. A separate appointment letter is neither required nor recommended.

(6) For a period not to exceed 2 years.

6. Renewal of Staff Appointments with Clinical Privileges. Practitioners with active staff appointments should apply for reappointment to the professional staff and renewal of clinical privileges at least 60 days before the expiration of their current appointment using a format similar to appendix K. Requests for renewal of staff appointments should include any proposed modifications to the practitioner's current clinical privileges. Applicants who have previously been granted an active staff appointment with clinical privileges need only update the information provided in the original PPIS, using a new PPIS form. Do not alter or modify original or previous forms. The application must identify the treatment facility and be signed and dated by the practitioner.

a. Reappointment is based on reappraisal of the practitioner's credentials (verified license and required certifications, professional performance, quality management information, results from NPDB query, judgement, clinical or technical skills, and health status) using predetermined department, specialty-specific criteria. At the time of reappointment, and at the time of renewal or revision of clinical privileges, current license is confirmed with the primary source or by viewing the practitioner's license.

b. Evaluation of practitioner-specific data and information generated by organizational quality management activities are of prime importance; and, it is imperative in the assessment of current competence, to justify reappointment to the medical or dental staff and renewal of clinical privileges. In cases where the practitioner is providing health care at civilian treatment facilities during the appointment period undergoing appraisal, it is both appropriate and recommended to solicit and consider

clinical performance information from these other facilities in determining current clinical competence, using a format similar to appendix O. Competency management is a medical and dental staff function.

c. The practitioner's department head, or the operational equivalent, must submit a PAR in support of reappointment to the staff and endorse the practitioner's application.

d. Both the practitioner's application and the PAR, with the department head's endorsement, are reviewed and subsequently endorsed by the directorate, credentials committee, and ECOMS or ECODS before approval by the privileging authority. The reappointment shall be granted:

(1) For a period not to exceed 2 years.

(2) In writing. Appendix K is a sample format. The appointment is effected when the privileging authority checks the approval block and signs and dates the endorsement page of the application. A separate appointment letter is neither required nor recommended.

7. Modifications of Clinical Privileges. Forward requests to modify previously approved clinical privileges to the privileging authority via the department head, directorate, credentials committee, and ECOMS or ECODS. Modification examples: (1) add or delete supplemental privileges to an existing core; (2) add or delete itemized privileges to an existing itemized list; (3) add or delete a core in its entirety.

a. Requests must include supporting documentation. Improved or new skills qualifying a practitioner for an augmentation in clinical privileges may be acquired through practice under the supervision of a practitioner privileged in the new procedure or through inservice or outservice education or training.

b. Modifications to clinical privileges do not alter the expiration date of the practitioner's current staff appointment.

c. Requests to voluntarily withdraw core clinical privileges to correct administrative errors become effective upon approval by the privileging authority. Requests for voluntary withdrawal

of core clinical privileges must not be accepted or acted upon, if the practitioner is the subject of allegations of substandard care or misconduct, or for any other reason except to correct administrative errors.

8. Privileging Trainees on Completion of Full-Time Inservice Training Programs. Within our multi-institutional system, demonstrated current competence is implicit in successful completion of a Navy internship, residency, or fellowship program. Concurrent with successful completion of a Navy postgraduate training program and licensure, the practitioner must be granted an active staff appointment with, at the minimum, core privileges specific to the training specialty; e.g., core privileges in operational medicine and primary care medicine for internships and core privileges in general surgery for general surgery residencies. Unlicensed practitioners may not be granted clinical privileges unless an exemption is obtained. To maximize the functionality of multi-institutional privileging, all Navy Medical Department training related to privileging must ensure compliance with the following procedures:

a. Ninety days before the completion of the training program, the trainee must apply for an active staff appointment with clinical privileges for the specialty in which he or she is receiving training, using appendix K. The active staff appointment with clinical privileges shall be granted concurrent with the completion of the training program and for a period not to exceed 2 years.

(1) Because trainees are monitored and supervised throughout their training programs, an initial staff appointment is not required; i.e., the appointment granted must be an active staff appointment.

(2) The formal appraisal of the trainee's current clinical competence is initiated by the program director using a PAR, at least 90 days before the completion of the training program. This PAR shall serve not only as an evaluation tool for the end of the training program, but also as evidence of current competence for the trainee's next duty station.

b. Upon reporting for post-training duty, the licensed practitioner is eligible for an active staff appointment with, at the minimum, core clinical privileges.

9. Privileges for MTF, DTF, MARFORPAC, MARFORLANT, HQMC, DENBN, or USNDC COs

a. Practitioners who are COs are not to provide health care services independently unless appointed to the medical or dental staff. COs may not grant professional staff appointments to themselves, but may grant professional staff appointments to their executive officers. COs and executive officers whose primary duties do not allow opportunity for clinical activity in their specialty may apply for primary care medical officer privileges if their credentials, experience, and current competence are commensurate. Privileging in such circumstances is not considered adverse and is not subject to the adverse privileging review process.

b. COs must apply for staff appointments with clinical privileges, using the following procedures:

(1) Follow the same procedures currently required for granting appointments to other practitioners assigned to the command in the same professional category, through completion of the endorsement by the chairperson of the ECOMS or ECODS. Leave the privileging authority's signature block on the endorsement page blank.

(2) After the chairperson of the ECOMS or ECODS completes the endorsement on the application and PAR, forward the following documents to HLTHCARE SUPPO Jacksonville. Retain copies of any originals forwarded.

(a) A copy of the practitioner's completed and verified ICF (to include recent NPDB query).

(b) The original, current application, including the ECOMS or ECODS endorsement page, requested privilege sheets, and updated PPIS.

(c) The original, current PAR or the last PAR completed by the CO's last duty station, including the

evaluation of provider-specific data and information generated by organizational quality management activities, if the application is based on an active staff appointment granted by the last duty station.

(d) Documentation of current competency if the application is for an initial active staff appointment or a reappointment. The PAR is the competency statement concerning the provider's clinical proficiency.

(e) A copy of the department, specialty-specific staff appointment and clinical privileging criteria.

(f) A copy of the relevant sections from the ECOMS or ECODS minutes, and credentials committee minutes when a credentials committee has been appointed, addressing the CO's application for staff appointment.

(g) HLTHCARE SUPPO Jacksonville processes CO privilege requests for the privileging authority.

c. The privileging authority, the Assistant Chief for Health Care Operations (MED-03) or Assistant Chief for Dentistry (MED-06), as applicable, shall indicate an appointment decision by signing and dating the endorsement page.

d. The completed application, PAR, ICF, and related documentation shall be returned for retention and maintenance by the command's professional affairs staff.

e. HLTHCARE SUPPO Jacksonville shall retain a copy of the completed application and PAR.

f. Renewal requests must have the documentation listed in paragraph 9b(2) forwarded to HLTHCARE SUPPO Jacksonville no less than 60 days before the practitioner's current appointment expires.

10. PCS Transfer

a. Practitioners reporting for permanent duty who previously held active staff appointments with, at the minimum, core clinical privileges, are eligible for active staff appointments

with clinical privileges at the gaining command without repeating an initial staff appointment period under the following conditions:

(1) The time since the expiration of the practitioner's last active staff appointment with clinical privileges does not exceed 2 years.

(2) The most current PAR verifies demonstrated current competence for the privileges requested. Appendix A must specifically address, in sections X and XI, the current clinical competency of all supplemental privileges granted.

b. For supplemental privileges, the practitioner must meet the privileging criteria relevant to the requested supplemental privileges at the gaining command. Denial of supplemental privileges at the gaining command for any of the following reasons is not an adverse privileging action:

(1) Failure to meet the privileging criteria for supplemental privileges at the gaining command.

(2) The inability of the gaining MTF or DTF to support the supplemental privileges due to facility restrictions, lack of support staff, or equipment.

(3) The health care demands placed on the MTF or DTF dictate the practitioner's assigned clinical duties shall not include the requested supplemental privileges.

11. Health Care Services Provided at Other DON Treatment Facilities

a. There are circumstances when a practitioner holding an active staff appointment with at least core clinical privileges or when a clinical support staff member expect to perform health care services at a treatment facility not under the cognizance of their current privileging authority. Examples are: temporary additional duty (TAD), additional duty (ADDU), annual training (AT), active duty training (ADT), inactive duty for training travel (IDTT), ADSW, or the voluntary provision of health care services. The following procedures apply in those situations:

(1) The holder of the practitioner's ICF informs the gaining privileging authority of the practitioner's current credentials and staff appointment with clinical privileges using a message, e-mail, fax, speed letter, or NAVGRAM in the appendix N, CTB format. The practitioner requests authority from the privileging authority of the gaining treatment facility, using a letter, message, e-mail, fax, speed letter, or NAVGRAM in the appendix Q format, to exercise his or her current privileges within the gaining facility. The CTB, appendix Q, and all related documentation are to be maintained in a file folder in the gaining facility's professional affairs office. This file is not, nor is it to be converted into, an ICF, see section 4.

(a) No application for privileges is necessary at the gaining facility. When practicing under the provisions of this paragraph, the practitioner functions as a member of the professional staff and participates fully in the gaining command's quality management program.

(b) The document granting the practitioner authority to practice should address any supplemental privileges currently held by the practitioner that cannot be supported by the gaining command by reason of facility or support staff limitations.

(c) If a temporary or AT, ADT, or ADSW assignment requires a practitioner to perform privileges not currently held, but for which the practitioner potentially meets the gaining facility and department privileging criteria, the practitioner may apply and be authorized to exercise the privileges at the gaining facility. Since each practitioner has only one privileging authority at any given time, the gaining facility must recommend and provide justification for augmentation of the practitioner's current privileges. The gaining command may then grant the practitioner's facility-specific, supplemental privileges, and must inform the practitioner's privileging authority of the action taken. The gaining command's documentation of competency, education and training, and justification for granting the supplemental privileges, shall be forwarded to the privileging authority for inclusion into the ICF. For example, an oral/maxillofacial surgeon, whose primary assignment is at a dental clinic, wants to maintain overall surgical competency by performing oral and maxillofacial surgery procedures at a local naval hospital.

The dentist would request appropriate clinical privileges at the naval hospital; and, the naval hospital would grant the privileges. The hospital would inform the dentist's privileging authority these privileges had been granted, and forward the appropriate documentation for inclusion in the provider's ICF being maintained at the dental clinic.

(2) The holder of the clinical support staff member's IPF informs the gaining CO of the member's education and training and license status using a message, e-mail, fax, speed letter, or NAVGRAM in the appendix N, CTB format, paragraphs 1, 2, 3, 5, and 6 (modified to address practice areas in which the member is currently competent, such as general medical-surgical nursing), 9 (modified to address current competency); and 10 (modified to read IPF vice ICF).

b. A practitioner is eligible to exercise privileges at all DON MTFs and DTFs as long as their staff appointment with clinical privileges is not currently restricted, has not expired or been terminated, and the practitioner meets the privileging criteria at the gaining command. The expiration date of the practitioner's current appointment is indicated on the CTB. If supplemental privileges are expected to be exercised at the gaining facility, communication between the gaining and parent facilities will be necessary to ensure the practitioner can meet the gaining facility's specialty-specific privileging criteria for any supplemental privileges.

c. Upon completion of duty for periods exceeding 4 continuous days, a PAR shall be completed and forwarded for inclusion in the practitioner's ICF.

d. When the practitioner provides recurring services at another treatment facility, the CTB is valid for the tenure of the practitioner's current staff appointment at the parent facility. A single PAR, covering the multiple duty periods, must be completed at the end of the last duty period and when the parent facility requests one be submitted as part of the privilege reappraisal process.

e. Practitioners holding initial staff appointments are not to be assigned duty to other facilities as a general rule. However, circumstances may arise that require exception to this rule; e.g., operational requirements; temporary relief of a

single practitioner assigned to an overseas, remote, or small facility; or to maintain outpatient support at nearby clinics not organizationally under the same privileging authority. Practitioners holding only initial staff appointments may be assigned such duty using the procedures described above, under the following conditions:

(1) The prospective gaining facility identifies in their request the specific scope of services necessary during the duty period.

(2) After a review of the scope of services, requested relative to the inventory of practitioners onboard who could satisfy the requirement, the parent facility privileging authority documents the rationale for a decision the requirement can be safely met with a practitioner who has not yet been granted an active staff appointment.

(3) The gaining privileging authority acknowledges the practitioner is acceptable.

(4) If the practitioner offered is not acceptable, the parent facility nominates another practitioner, if available, or refers the request to higher authority for resolution.

12. Permanent Assignment to the Operational Forces

a. Fixed MTFs or DTFs must support the operational forces by ensuring practitioners assigned to their commands who are in receipt of orders to an operational assignment are currently competent, professionally qualified, and have been granted active staff appointments with, at a minimum, the core privileges required to function in the prospective operational assignment, before the practitioner's detachment from the fixed MTF or DTF. The practitioner's ICF shall be forwarded to the privileging authority as prescribed in section 4, paragraph 5 of this instruction. A NPDB query shall be included in the licensed practitioner's ICF before transfer to operational forces. The PAC upon receipt of orders, must check the ICF for the NPDB query. If there is no NPDB query, call HLTHCARE SUPPO Jacksonville for date of last query. If there is no query, HLTHCARE SUPPO Jacksonville shall query and forward query to the PAC. The ICF can be forwarded without the NPDB query, but the

cover letter must include: (1) date HLTHCARE SUPPO Jacksonville was notified of need for query; (2) HLTHCARE SUPPO Jacksonville must be sent a copy of the cover letter, to assure appropriate forwarding of query. The query shall be forwarded, by HLTHCARE SUPPO Jacksonville, to the operational privileging authority when received.

b. Practitioners at fixed MTFs or DTFs who shall require core privileges not currently held, to function in their prospective operational assignment must be provided the training necessary to qualify them for the required privileges before the expected date of detachment. Using the procedures described previously for augmentation of clinical privileges, the practitioner shall be granted the necessary privileges, if qualified, before the date of detachment and in time to forward the ICF to the gaining command. If the practitioner proves to be not qualified for the core privileges required for the operational assignment, a change of orders is indicated and the Navy Personnel Command shall be notified.

c. If practitioners desire to practice at another facility while assigned to the operational forces, they may do so using the procedures described in paragraph 11a(1)(c) of this section.

13. Temporary Augmentation to the Operational Forces, Afloat. It is not uncommon for reservists and active duty practitioners to receive, on short notice, TAD orders to an afloat (ship) operational assignment. Navy ships represent an extension of Navy Medicine at the deckplates. Due to the nature of ship to ship communication, and the immediacy of the orders, it is often impossible to complete the appendix Q process. To assure patient safety and the highest standard of medical care to our operational forces, the following procedures apply:

a. Fixed MTFs or DTFs must support the operational forces by ensuring practitioners assigned to their commands who are in receipt of TAD orders to an afloat operational assignment are currently competent, professionally qualified, and have been granted active staff appointments with, at a minimum, the core privileges required to function in the prospective TAD afloat operational assignment. Time permitting, practitioners in receipt of TAD afloat operational orders, who require core privileges not currently held to function in their operational

assignment, must be provided the training necessary to quality them for the required privileges before the expected date of mobilization.

b. The holder of the practitioner's ICF informs the gaining TAD afloat operational command of the practitioner's current credentials and staff appointment with clinical privileges using the CTB, appendix N, format by message, e-mail, speed letter, fax transmittal, or NAVGRAM. The completion of appendix Q format is not necessary for these specific providers. A practitioner holding a current medical staff appointment with clinical privileges can exercise the privileges aboard ship in a TAD afloat operational status. It is understood the practitioner agrees not to exercise privileges afloat that exceeds the medical facilities immediately available.

c. If the TAD operational assignment is of such a nature the gaining command cannot be located to transmit a CTB, the practitioner may hand-carry their CTB to present to the gaining operational command upon arrival.

14. Credentials Review and Privileging Process at Operational Commands

a. The principles and procedures for granting staff appointments with clinical privileges at fixed MTFs or DTFs prescribed in this section, are applicable to practitioners and privileging authorities in the operational arena. Modifications to these procedures due to unique operational requirements or organizational structure, shall be specified in local implementing directives.

b. The privileging authorities for practitioners reporting for PCS operational assignments are in paragraph 6 of the basic instruction.

c. Practitioners reporting to operational assignments shall be granted privileges at their detaching commands. Because practitioners reporting to operational assignments from fixed MTFs or DTFs will have been granted an active staff appointment with clinical privileges at their detaching commands, there is no need for operational privileging authorities to grant initial staff appointments.

15. Selected Reserve Practitioners

a. All Selected Reserve practitioners shall have their credentials reviewed and verified and shall apply for and be granted staff appointments with clinical privileges consistent with the procedures applicable to active duty practitioners by the holder of their ICF designated in section 4, paragraph 3.

b. When a Selected Reservist is assigned to IDTT, AT, or ADT involving the provision of health care services at the facility, the gaining command shall request a CTB from the CCPD.

c. When a Selected Reservist is assigned to ADSW involving the provision of health care services at the facility, the gaining command shall request a CTB from the CCPD. When the CTB is forwarded from the CCPD to the gaining command, MED-07 is informed under separate cover (message, e-mail, fax, or speed letter).

16. Ongoing assessment of practitioner performance is documented using any mechanism the facility or operational site mandates to meet the facilities needs and operational mission. Relevant information from organizational quality management activities is considered when evaluating professional performance, judgment, and clinical and technical skills (clinical competence). Whatever mechanism is used, this practitioner specific quality management information shall be easily accessible and maintained at the facility for the 2-year reappointment or renewal of privileges timeframe.

a. Practitioner Specific Data

(1) Information generated through the command's quality management activities and risk management program to include process and outcome measures.

(2) Data reflecting workload (productivity).

(3) Results of peer review activities.

(4) Patient feedback data and information.

(5) Documentation of training or continuing education, including ACLS or ATLS required to meet specialty-specific staff appointment or privileging criteria.

(6) Documentation of practitioner's health status (i.e., located on the PPIS) in terms of ability to practice in the area in which privileges are sought.

(7) Other practitioner-specific information used in evaluating or documenting the clinical performance of the practitioner, including appraisals of nontrainees practicing under supervision.

b. A PAR, appendix A, shall be completed on each practitioner providing health care services by the privileging authority at intervals not to exceed 2 years and placed in the ICF. The purpose of the PAR is to permanently document the periodic appraisal of practitioner conduct, competence, and performance required by reference (a). The PARs are the primary documents used to support the granting and renewal of active staff appointments. Additionally, the PARs shall be reviewed at the time of fitness report preparation. Any evaluation element marked UNSAT in section VI or VIII shall be accompanied by explanatory remarks placed in section XII or on attached additional sheets. Department heads are required to make appropriate comments in section X regarding the practitioner's clinical competence in practicing all privileges granted, both core and especially supplemental privileges in section XI. PARs must be completed on health care practitioners:

(1) During the latter portion of initial staff appointments.

(2) Before completing inservice graduate professional education or training programs.

(3) Upon detachment incident to transfer, separation, termination of employment, or retirement. When the member has detached from the command without an opportunity to review and sign the PAR, provide member with a copy of the PAR at his or her next duty station, etc., with a "date/copy to practitioner" annotated on the bottom of the original PAR filed in member's ICF.

(4) Upon completion of temporary duty exceeding 4 continuous days; permanent assignment to an operational unit; or temporary assignment to another operational unit exceeding 4 continuous days.

(5) At the time of reappointment to the professional staff.

(6) When significant new information about a detaching practitioner's performance or conduct becomes available after the practitioner detaches. In this case, a special PAR shall be completed by the appropriate department head, endorsed by the credentials committee, the ECOMS or ECODS, and forwarded to the practitioner's gaining privileging authority. When received by the gaining privileging authority, the PAR shall be reviewed and endorsed by the gaining department head, the practitioner, credentials committee, and ECOMS or ECODS before inclusion in the practitioner's ICF. The special PAR is the appropriate vehicle to forward results of Judge Advocate General Manual Investigations (JAGMANs), civilian external peer review, or investigations into allegations of misconduct or substandard care to the gaining privileging authority. Information included on the detaching PAR need not be reiterated on the special PAR. Potentially adverse PARs must be acted upon and finalized by the sending command.

c. The mechanisms used at the facility level, to gather and maintain practitioner specific quality management data, shall be handled with the same security and confidentiality precautions required for all documents generated through quality assurance programs. Follow reference (m).

17. Support of the Armed Forces Medical Examiner (AFME) System. The AFME System provides support for medico-legal death investigations to all DoD MTFs or DTFs. The range of support includes onsite performance of autopsies by deputy or regional medical examiners, telephonic consultations, and written reports. Deputy and regional medical examiners generally hold privileges granted by the Armed Forces Institute of Pathology (AFIP). Deputy and regional medical examiners are authorized to perform autopsies upon presentation of their AFME credentials to the CO. An application for staff appointment with clinical privileges is not required for this service. See reference (u).

18. Health Care Services Provided by Non-DON Trainees. Non-DON trainees performing health care services under supervision as part of a cooperative agreement with a training institution are not eligible for a staff appointment with clinical privileges. An ICF for such practitioners is not required. Documentation of the following must be maintained in the MTF or DTF professional affairs office:

a. Written authorization from the privileging authority for the practitioner to provide a specified scope of health care services while under the supervision of a specified practitioner who holds a professional staff appointment with clinical privileges in the same or similar specialty as the trainee.

b. The designated supervisor is responsible for oversight, coordination, and any required follow-up care related to the health care services provided by the trainee.

c. A copy of the evaluation completed at the conclusion of the training period.

d. Written confirmation from the trainee's primary training institution that the practitioner's qualifying credentials required by appendix B, as applicable, have been verified.

19. Support for the Organ and Tissue Procurement Program and the Armed Services Medical Regulating System. Organ donations and transplants conducted by organ and tissue procurement teams, per reference (t), and treatment provided within Navy MTFs or DTFs by personnel assigned to the Armed Forces Medical Regulating System to patients under their care, per reference (u), are authorized to be performed without formal credentials review and privileging under this instruction. However, personnel assigned in support of these programs must present sufficient documentation (e.g., official orders, assignment letter, or identification card) to the CO of the MTF or DTF to establish their authorization to perform the services.

SECTION 3

CLINICAL SUPPORT STAFF AND INDIVIDUAL PROFESSIONAL FILES (IPFs)

1. General. COs shall ensure that assignments to patient care activities of clinical support staff, as defined in section 5, are based on consideration of the staff member's verified qualifying degrees and licenses (all State licenses or certifications held within the last 10 years), past professional experience and performance, education and training, health status, and current competence as compared to specialty-specific criteria regarding eligibility for defined scopes of health care services. Primary source verification (PSV) is a function under the JCAHO medical staff standards; therefore, there is no requirement to primary source verify clinical support staff nursing certifications. COs shall ensure procedures are in place for consideration of the staff member's verified qualifying degrees, using the criterion established by the corps chiefs and directors.

a. COs shall maintain an IPF on all clinical support staff assigned to, employed by, contracted by, or under partnership agreement with the command. A Privacy Act Statement (PAS), appendix I, is to accompany each IPF. The IPF shall contain documentation described in appendix S.

b. The items described in appendix B shall be collected before the individual being selected for, employed by, or contracted to the DON, or assigned clinical duties other than under direct supervision as defined in section 5.

c. Responsibility for initial collection and verification of the items listed in appendix B is as follows:

(1) For direct accessions, recalls to active duty, and interservice transfers to DON, the Commander, Navy Recruiting Command is responsible, following section 4 of this instruction. The applicable professional review board appointed under references (n) and (o) shall confirm the required verifications of the credentials information.

(2) For new civil service employees, the servicing civilian personnel office shall collect and verify the required credentials information, appendix B, and shall furnish such information to the CO for review before hiring the individual.

(3) For new contract employees contracted directly to the MTF or DTF, the CO is responsible. If the contract involves an intermediate contracting agency, the contracting agency is held responsible. Additionally, this information must be furnished to the MTF or DTF PAC at least 30 days before the individual begins work under the contract.

d. IPFs shall contain a signed PAS, appendix I.

2. Disposition and Maintenance of IPFs. The disposition and maintenance of IPFs follow the same guidelines for ICF disposition and maintenance in section 4.

3. Clinical Performance Appraisal. The ongoing assessment of the clinical performance of clinical support staff shall be, in part, through the command's performance data and information, generated through the organizational quality management activities. Upon transfer, separation, termination of employment, or retirement, and at intervals not to exceed 2 years, an appraisal of each clinical support staff member's clinical performance and conduct shall be completed with documentation placed in the member's IPF. Appraisals are required only for clinical support staff assigned to clinical duties. The appraisal must identify and address, at a minimum, the following elements:

a. Activity completing the appraisal.

b. Identification of the member being appraised including grade or rate, social security number (SSN), and designator, if applicable.

c. Purpose of the appraisal (transfer, separation, periodic).

d. Inclusive dates of the appraisal period.

e. Clinical department assignments and scope of clinical responsibilities.

f. Clinical activity indicators; e.g., average daily inpatient census and average number of outpatient visits.

g. Professional development activities; e.g., participation in continuing professional education, publications, presentations, and recognition of professional achievements.

h. Trends, positive or negative, identified through the command's performance data and information, generated through the organizational quality management activities.

i. Incidents of reportable misconduct as defined in reference (d).

j. Review of the appraisal by the appropriate director.

k. Review of the appraisal by the member and the opportunity to make comments.

4. Disposition of Performance Appraisals. The original of the clinical performance appraisal is to be placed in the member's IPF. Upon detachment from the command, copies of all clinical performance appraisals prepared at the command are to be retained in a secure file at the command for 10 years. After 10 years, the file shall be forwarded to the provider, if current address is known, or destroyed as authorized by reference (f). The retained performance appraisals serve as a record to respond to future inquiries regarding the clinical support staff member's professional performance and staff responsibilities while assigned to the command.

5. Health Care Services Provided at Other DON Treatment Facilities. When clinical support staff members are assigned to provide health care services at a DON treatment facility other than that to which they are permanently assigned, employed, contracted, or under partnership agreement with, and the gaining treatment facility is under the cognizance of another privileging authority, the sending facility forwards the required credentials information using the appendix N (CTB) format. The information may be conveyed using a speed letter, NAVGRAM, e-mail, or message, with the appropriate blocks completed as indicated in paragraph 11 of section 2. The gaining facility is required to provide, to the sending

facility, an appraisal of the clinical support staff member if the assignment exceeds 4 days. A single appraisal, covering all such assignments over the sending facility's current 2-year appraisal period for the member, may be used when the member is temporarily assigned more than once to the same facility. The gaining facility shall retain a copy of appendix N (CTB) and the appraisal in a file folder for a period of 10 years. This file is not, nor is it to be converted into, an IPF. See section 4, paragraph 3c(2).

6. Contingency Assignment. When a clinical support staff member has been given a contingency assignment, upon receipt of orders indicating imminent deployment the PAC shall prepare a CTB (appendix N) generated from the centralized computer database, and forward it to the contingency assignment. A copy of the current CTB shall be maintained in section II of the ICF.

SECTION 4

INDIVIDUAL CREDENTIALS FILES (ICF)

1. General. Upon accession into or employment by the DON, each health care practitioner, including military trainees, shall have credentials information collected, verified, and incorporated into an ICF, following the structure and content guidelines in appendix R. A signed PAS, appendix I, shall accompany each ICF. The ICF is maintained throughout the practitioner's tenure with the DON. Do not duplicate information contained in the ICF in any other files used in the administration of trainees. Compliance with this instruction results in a single, complete, verified ICF for each practitioner.

2. Collection and Verification of Credentials Documents

a. All items in appendix B shall be collected, verified, and evaluated before an individual is selected for DON service, employed by or contracted to the DON, or granted a professional staff appointment by a privileging authority of a DON MTF or DTF.

b. Responsibility for collection and verification of the items listed in appendix B is as follows:

(1) For direct accessions, recalls to active duty, and interservice transfers to the DON, the Commander, Navy Recruiting Command is responsible, following the documentation guidelines specified in this section. The applicable professional review board appointed under references (n) through (q) confirm the verifications of the required credentials documents. The Assistant Chief for Education, Training, and Personnel (MED-05) ensures the accession package is complete before submission to the professional review board.

(2) For students reporting from Armed Forces Health Professions Scholarship Program (AFHPSP) and Uniformed Services University of the Health Sciences (USUHS) programs, the gaining privileging authority is responsible.

(3) For new civil service employees, the servicing human resources office is responsible. The civilian personnel office forwards the information to the appropriate privileging authority before hiring the individual.

(4) For new contract practitioners, if the individual is contracted directly to the treatment facility, the CO is responsible. If the contract involves an intermediate contracting agency, the contracting agency is responsible and forwards the information to the gaining privileging authority at least 30 days before the individual begins work under the contract.

c. The items listed in appendix R, plus any related new or updated information, summaries of JAGMAN investigations or liability claims in which the individual was a principle party, and PARs, must be maintained in the ICF. Summaries of information of an adverse nature, accrued during DON service and becoming available after the practitioner leaves DON service, shall be included and maintained in the practitioner's ICF.

d. The practitioner is responsible for providing accurate and current evidence of professional qualifications. This may be in the form of documents, letters of reference, statements made, or information provided during the accessions or credentials review and privileging process. The practitioner shall immediately inform the holder of their ICF of any change in professional qualification, including health status, which could impair their ability to provide safe, competent, authorized health care services.

e. Copies of documents provided by the practitioner being evaluated are not required to be certified true copies, but shall serve as reference documents for the verification process. References (a) and (e) require independent PSV of the following credentials. These credentials are further described in appendix R.

(1) Qualifying degree. Educational Commission for Foreign Medical Graduates (ECFMG), Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), or Fifth Pathway certificates for those graduates of foreign medical schools, other than approved schools in Canada and Puerto Rico, constitutes evidence of the qualifying degree.

(2) All clinically related postgraduate training.

(3) All professional qualifying certifications.

(4) All State licensures and certifications held within the last 10 years including all voluntary lapses of licensure. If the practitioner does not possess a licensure or certification exemption or is not otherwise specifically authorized to practice independently without a licensure or certification, the practitioner shall hold at least one current, valid, unrestricted licensure or certification. A current, valid, unrestricted licensure or certification is one which has not expired or been suspended or revoked, one which the issuing authority accepts and considers quality assurance (quality management) information, and not subject to restriction pertaining to that scope, location, and type of practice ordinarily granted all other applicants for similar licensure or certification in the granting jurisdiction.

f. The PSV is required only one time. Credentials do not require reverification by gaining privileging authorities unless a change in the status of the credential has occurred since the last verification or some reason exists to doubt the authenticity of the credential. At time of reappointment to the medical staff or upon the granting or renewal of privileges, the license shall be verified. The current licensure is confirmed by viewing the applicant's current license or certificate, making a copy of the credential, and placing the copy in the ICF with appropriate documentation per paragraph 2(j)(1-4) of this section. Under statutory law, several States do not authorize the copying of licenses. In this case document viewing of the license, the date, the expiration date of the license, your name, title, and facility.

g. The PSV must be independent; i.e., the member cannot complete the verification process.

h. Acceptable sources and methods of verification:

(1) Contact with the primary source or with an agency that has obtained PSV, i.e., American Medical Association (AMA) master file. Telephonic verification is acceptable. Verification obtained by parties external to the DON that meets the DON verification standards described herein is acceptable.

(2) Professional organization's Web site provided:

(a) The information is obtained directly from the professional organization's Web site. Use of the Web site of another recognized professional organization (such as the Administrators in Medicine site of the Association of Medical Board Executive Directors) is permitted if it is used as the platform to reach the intended site. If the information has a disclaimer and is not encrypted, the site cannot be used as a PSV site. The MTF/DTF and, when applicable, its credentials verification office (CVO) must confirm the Web site used is the professional organization's official Web site.

(b) The MTF/DTF and, when applicable its CVO, should assure itself the source Web site, when not located at, and under the direct control of, the professional organization, receives its information directly from the professional organization's database through encrypted transmission. When the source Web site is located at, and is under the control of, the professional organization, the MTF/DTF and, when applicable its CVO, should assure itself that if the Web site does not receive its information from the database by encrypted transmission, it is protected from alteration by unauthorized individuals.

(c) The information on the Web site contains all of the information required for the PSV process of the specific credential.

(d) The Web site should contain sufficient information to properly identify the applicant. For example, name alone might not be sufficient to distinguish the applicant.

(e) The MTF/DTF and, when applicable its CVO, should know the currency of information on the Web site.

(f) Information on the Web site that is supplemental to the information undergoing PSV, such as a State licensing board's Web site including information on the individual's specialty, is not to be used as PSV data, although it may be useful in evaluating the overall package of information gathered by the MTF/DTF on the practitioner.

(g) Any discrepancy between information provided by the applicant and on the Web site should be followed up with the professional organization by correspondence or telephone.

(h) The fact adverse information is not presented on the Web site should not deter the MTF/DTF from contacting the professional organization by telephone or written correspondence if the other information gathered by the MTF/DTF warrants it.

(i) All of the information on source data must be placed in the ICF.

(j) The identification of the medical staff specialist who made the Web site contact and gathered the information, along with the date, should be entered onto the Web site printout or other record of the information. If the MTF/DTF uses a CVO that gathers information directly from a professional organization's Web site, they must ensure the CVO identifies the employee who made the Web site contact and gathered the information along with the date of that action. If that information is in turn transmitted electronically to the MTF/DTF, the MTF/DTF must also identify the medical staff specialist who gathered the information from the CVO, along with the date.

(k) The MTF/DTF's use of a CVO that gathers information directly from a professional organization's Web site is subject to the guidelines for the use of CVOs found in references (b) or (c). For board certifications, the official American Board of Medical Specialty (ABMS) Directory of Board Certified Medical Specialists published by Marquis Who's Who in cooperation with the ABMS; or, listings published by certifying boards may be used as verification.

(3) Listings published or released by certifying agencies; e.g., the National Commission on Certification of Physician Assistants (NCCPA); the Academy of Certified Social Workers (ACSW); and, the American Nurses Credentialing Center (ANCC).

(4) Confirmation by HLTHCARE SUPPO Jacksonville, FL through CCQAS the document has been verified.

(5) When unable to verify education and training, or qualifying degrees due to school closures or other unforeseen events, verify attempts made, persons contacted (title and telephone number), ensuing discussion, and reason verification cannot be completed. At this point the record is considered complete and can be forwarded to the ECOMS and ECODS for action. Upon recommendation of the ECOMS and ECODS, the privileging authority may grant a staff appointment without the required verification. This decision shall be supported by a preponderance of evidence the requirement in question has been met. The decision and justification, including letters of inquiry and telephone calls, shall be documented with a copy placed in the practitioner's ICF. Place the documentation in the same section the credential in question would have been placed if available.

i. All discrepancies require resolution through direct contact with the primary source.

j. Acceptable documentation of verification clearly identifies the:

(1) Agency, position, telephone number, and person supplying confirmation of authenticity.

(2) Publication or listing, if such was the source of verification.

(3) Agency, position, and person documenting the verification.

(4) Date of verification, facility, and PACs signature.

k. The documentation of PSV is placed on or appended to the document being verified and placed in the ICF.

l. ICFs shall contain a signed PAS, appendix I.

m. While the responsibility for fees required to obtain and maintain basic qualifying licenses and certificates lies with the practitioner, appropriated funds may be used to pay, in advance if required, fees required to obtain required verifications per reference (t).

3. Maintenance of ICFs

a. Members have only one ICF.

b. ICFs are to be maintained in a secure area. If the practitioner provides health care services at a facility not under the cognizance of the privileging authority holding their ICF, the holder of the ICF forwards the applicable credentials and privilege information to the gaining privileging authority using the format in appendix N (CTB).

c. All naval Reserve practitioners' ICFs shall be maintained at the CCPD. The CCPD functions in the following manner:

(1) The CCPD is a department of the HLTHCARE SUPPO Jacksonville, FL. The CCPD will centralize the credentials review and privileging process for Reservists; manage Reserve ICFs and IPFs; coordinate initial privileging with MTFs and DTFs; maintain a credentials and privileging committee; renew privileges; use the CCQAS database; and maintain archived active duty and Reserve ICFs and IPFs from closed or disestablished activities and facilities for at least 10 years.

(2) ICFs and IPFs for civil service and contract providers who are also selected Reserves shall be maintained by the CCPD. The CCPD shall provide an Inter-facility Credentials Transfer and Privileging Brief (ICTB) to the privileging authority for the facility where the reservist works.

(3) Selected Reserves shall apply for an initial staff appointment with clinical privileges to the CCPD. The period of initial privileging shall continue per this instruction. Concurrent civilian practice information shall be collected from each civilian affiliation by the CCPD and placed in the ICF.

(4) The Reserve provider shall be evaluated following all periods of clinical service in a military MTF or DTF and a PAR with a CTB shall be submitted. The facility shall be responsible for the collection and documentation of necessary practitioner specific data and information generated by organizational quality management activities. The PAR shall be completed per this instruction. PARS, quality management data, and civilian activity data shall be acted upon by the CCPD in the granting or renewing of privileges. The CCPD shall establish a credentials review and privileging committee for this purpose. The CCPD

shall be queried by Reserve readiness commands (REDCOMS) to determine if a reservist is privileged before processing training or support requests. A CTB will be sent to the gaining command if privileged. Adverse or additional privileging action shall follow reference (d).

4. ICF Contents

a. Only documentation specified in appendix R may be placed in a practitioner's ICF.

b. Practitioners have a right to review, make comment on, and receive copies of all material in their ICF. The NPDB queries may not be copied per the Health Care Quality Improvement Act of 1986.

c. Before material of an adverse nature (fact or opinion which reflects negatively on clinical competence, conduct, or clinical performance) is placed in an ICF, the practitioner shall be provided a copy and given an opportunity to comment thereon. Statements by a practitioner in reply to the adverse material must also be included in the practitioner's ICF. Except material ordered inserted in an ICF by Chief, Bureau of Medicine and Surgery, adverse matters shall undergo peer review as defined in section 5 before its placement in the ICF.

d. Removal of material from the ICF may only be accomplished per reference (m).

5. ICF Disposition

a. Privileging authorities are to retain a copy when forwarding original ICFs using the procedures described below. Upon confirmation of receipt of the original ICF, the copy may be destroyed per reference (f) or forwarded to the gaining authority for their use.

b. For practitioners transferring on PCS orders to a DON clinical, administrative, or research assignment within the military health system, the original ICF is forwarded, return receipt requested, to reach the gaining privileging authority at least 15 days before the practitioner's scheduled arrival. In the event that is not possible for the clinical practitioners, the CTB shall be sent within the same required timeframe. The ICFs of practitioners transferring to nonclinical assignments

outside the military health care system shall be forwarded to the HLTHCARE SUPPO Jacksonville with a letter informing the practitioner of the ICF location. Practitioners shall provide changes and updates of licensure status and credentials information to the holder of their ICFs. Upon subsequent assignment to a clinical billet, the holder of the ICF shall forward the ICF to the gaining privileging authority.

c. For practitioners ordered to full-time inservice graduate education, the ICF shall be forwarded to the gaining training facility using the procedures in paragraphs 5a and 5b above.

d. For practitioners ordered to FTOS GME, the original file shall be maintained at the practitioner's last clinical command, with a letter informing the practitioner of the ICF location. Practitioners are to provide changes and updates in credentials information to the holder of their ICF. Upon completion of FTOS, the holder of the ICF shall forward the ICF to the gaining privileging authority.

e. For practitioners who have separated or terminated DON employment:

(1) Without a history of permanent adverse privileging action or reportable misconduct, as defined in reference (d), the original ICF shall be forwarded to the HLTHCARE SUPPO Jacksonville, and be retained in a closed status for at least 10 years, at which time it must be forwarded to the practitioner, if current address is known, or destroyed as authorized by reference (f).

(2) With a history of permanent adverse privileging action or reportable misconduct, as defined in reference (d), the original ICF shall be forwarded to MED-OOL (legal), return receipt requested, for indefinite retention.

f. For Reserve practitioners who have separated or terminated DON employment:

(1) Without a history of permanent adverse privileging action or reportable misconduct, as defined in reference (d), the original ICF shall be retained at the CCPD for at least 10 years, at which time it must be forwarded to the practitioner, if current address if known, or destroyed as authorized by reference (f).

(2) With a history of permanent adverse privileging action or reportable misconduct, as defined in reference (d), the original ICF shall be forwarded to MED-OOL (legal), return receipt requested, for indefinite retention.

g. For archived ICFs and IPFs from closed facilities, retain or destroy per paragraphs 5e(1) and (2) and, 5f(1) and (2) above.

h. When forwarding or disposing of ICFs, note the provisions of paragraph 6 of this section.

6. Local Retention of Credentials Information. Upon retirement, privileging authorities shall maintain copies of all PARs with associated privilege sheets and applications for staff appointments or with associated requests and authorizations to exercise privileges, including endorsements, completed by the privileging authority for 10 years. Upon detachment of practitioners incident to permanent change of station transfer, separation, retirement, or termination of employment, copies of these documents shall be made before the appropriate disposition of the ICF per paragraph 5 above. Responses to requests for information regarding a current or former practitioner shall adhere to reference (m). Forward requests for information concerning reservists to CCPD per reference (m).

SECTION 5

DEFINITIONS

1. Abeyance. The temporary removal of a privileged practitioner from clinical duties while an inquiry into allegations of practitioner misconduct or professional impairment is conducted. Abeyances cannot exceed 28 days. A privilege abeyance is nonpunitive and is not an adverse privilege action.

2. Adverse Privileging Action. The denial, suspension, limitation, or revocation of clinical privileges based upon privileged practitioner misconduct, or professional, medical, or behavioral impairment. The termination of professional staff appointment based upon conduct incompatible with continued professional staff membership is also an adverse privileging action. Providers who have been diagnosed as alcohol dependent (alcoholic) or drug dependent or as having an organic brain or psychotic mental disorder are considered impaired providers (refer to definition of impairment in this section).

3. Alcohol or Drug Abuse. The use of alcohol or other drugs to an extent that it has an adverse effect on performance, conduct, specialty, mission effectiveness, or the user's health, behavior, family, or community. The wrongful or illegal possession or use of drugs in any amount also constitutes drug abuse.

4. Clinical Privileging. The process whereby a health care practitioner is granted the permission and responsibility to independently provide specified medical or dental care within the scope of his or her licensure, certification, or registration. Clinical privileges define the scope and limits of practice for individual practitioners. Privilege categories include:

a. Regular Privileges. Core and supplemental privileges.

b. Temporary Privileges. Granted in situations when time constraints do not allow full credentials review. Time limited, granted only to fulfill pressing patient care needs.

c. Supervised Privileges. Used to identify the privileging status of nonlicensed and noncertified providers who are not independent.

5. Clinical Support Staff. Personnel who are required to be licensed under reference (e), but are not included in the definition of health care practitioners. This category includes dental hygienists and nonprivileged nurses.

6. Credentials. Documents that constitute evidence of qualifying education, training, licensure, certification, experience, and expertise of health care providers.

7. Credentials Review. The application and screening process whereby health care providers have their credentials evaluated before being selected for DON service, employed by the DON, granted clinical privileges, or assigned patient care responsibilities.

8. Current Competence. The state of having adequate ability to perform the functions of a practitioner in a particular discipline as measured by meeting the following conditions:

a. Privileged to independently practice a specified scope of care at any time within the past 2 years.

b. Authorized to practice a specified scope of care under a written plan of supervision at any time within the past 2 years.

c. Completed formal graduate professional education in a specified clinical specialty at any time within the past 2 years.

d. Actively pursued the practice of his or her discipline within the past 2 years by having encountered a sufficient number of clinical cases to represent a broad spectrum of the privileges requested.

e. Satisfactorily practiced the discipline as determined by the results of practitioner-specific data and information generated by organizational quality management activities.

9. Denial of Privileges. An adverse privileging action taken by a privileging authority which denies privileges requested by a practitioner when those privileges are of a nature which would normally be granted at the facility to a practitioner of similar education, training, and experience occupying the same billet.

A denial shall be imposed by a privileging authority only after the opportunity for a peer review hearing has been afforded the practitioner.

10. Disability (Physical). Any impairment of function due to disease or injury, regardless of the degree, which reduces or precludes an individual's actual or presumed ability to engage in gainful or normal activity. The term physical disability includes mental disease, but not such inherent defects as personality disorders and primary mental deficiency, although they may render a member unsuitable for military duty.

11. FAC(U) Practitioners. Practitioners in the Marine Corps claimancy.

12. Health Care Providers. Health care practitioners and clinical support staff collectively.

13. Health Care Practitioners (Licensed Independent Practitioners). Licensed military (active duty and Reserve) and DON civilian providers (Federal civil service, foreign national hire, contract, or partnership) required by reference (a) to be granted delineated clinical privileges to independently diagnose, initiate, alter, or terminate health care treatment regimens within the scope of their licensure. This includes physicians, dentists, marriage and family therapists, nurse practitioners, nurse midwives, nurse anesthetists, clinical psychologists, optometrists, clinical dieticians, podiatrists, clinical social workers, pharmacists, physical therapists, occupational therapists, audiologists, speech pathologists, and physician assistants (PAs). For the purposes of this instruction, individuals enrolled in training programs leading to qualification for clinical privileges and American Red Cross volunteers in any of these disciplines are also considered health care practitioners.

14. Impairment. Any personal characteristic or condition which may adversely affect the ability of a health care provider to render quality health care. Impairments may be professional, medical, or behavioral. Professional impairments include deficits in medical knowledge, expertise, or judgement. Behavioral impairments include unprofessional, unethical, or criminal conduct. Medical impairments are conditions which permanently impede or preclude a

practitioner from safely executing responsibility as a health care provider or from rendering quality health care or any medical condition requiring convening of a medical board.

15. Intravenous Conscious Sedation. Sedation for which there is a reasonable expectation the sedation may result in the loss of protective reflexes in a significant percentage of patients.

16. License. A grant of permission by an official agency of a State, the District of Columbia, a Commonwealth, territory, or possession of the United States to provide health care within the scope of practice for a discipline. In the case of a physician, the physician license must be an active, current license that is an unrestricted license and is not subject to limitation on the scope of practice ordinarily granted to other physicians, for a similar specialty, by the jurisdiction that granted the license. This includes, in the case of such care furnished in a foreign country by any person who is not a national of the United States, a grant of permission by an official agency of that foreign country for that person to provide health care independently as a health care professional. Authorized licensing jurisdictions for health care personnel are specified in references (b) through (e). For the purpose of this instruction, "license" and "licensure" shall include certification and registration as appropriate for the provider type.

a. Current. Active, not revoked, suspended, or lapsed in registration.

b. Valid. The issuing authority accepts, investigates, and acts upon quality assurance information, such as practitioner professional performance, conduct, and ethics of practice, regardless of the practitioner's military status or residency.

c. Unrestricted. Not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction.

17. Limitation of Privileges. An adverse privileging action taken under reference (d) by a privileging authority which permanently removes a portion of a practitioner's clinical privileges. A limitation shall be imposed by a privileging authority only after the opportunity for a peer review hearing has been afforded to the practitioner.

18. Peer Review. Offers a practitioner the forum for problem solving and action as indicated. Peer review is conducted at a particular level, or tier, within the locally defined medical or dental staff organizational hierarchy. For example, in a hospital or dental center where professional staff monitoring is done by committees, the first or lowest level of peer review is at the committee, traditionally followed by the ECOMS or ECODS as the second level. Likewise, if these functions are performed within departments, these constitute the first or lowest level, followed by the service or directorate and ECOMS or ECODS as the second and third levels. Ordinarily, peer review is not conducted above the first level if consensus is reached. Additionally, when the consensus agrees there are grounds for adverse actions, reference (d) shall be followed.

19. Professional Staff Appointment. Formal, written authorization to perform patient care with delineation of authorized clinical privileges. Reflects the relationship of the provider to the medical staff. Appointment types include:

a. Initial Staff Appointment. The first Navy Medical Department professional staff appointment, granted for a period not to exceed 12 months, giving the practitioner the opportunity to demonstrate to the privileging authority current clinical competence, and the ability to comply with the facility's policies, procedures, bylaws, and code of professional ethics. This duration of time reflects the provisional (initial) staff appointment period.

b. Active Staff Appointment. Staff appointments granted to practitioners who successfully complete the initial staff appointment period. The active staff appointment period is 24 months.

c. Affiliate Staff Appointment. Granted to providers meeting all qualifications for membership in the medical staff after successfully completing the initial appointment period, but who are neither assigned organizational responsibilities nor expected to be full participants in activities of the medical staff. May apply to consultants, resource sharing personnel, part-time contracted staff. Affiliate members must conform to all medical staff bylaws. The affiliate staff appointment period does not exceed 24 months.

d. Temporary Staff Appointment. Granted in situations when time constraints do not allow full credentials review. Required when providers practicing under temporary privileges will be admitting patients. Relatively rare, used only to fulfill pressing patient care needs. The temporary staff appointment period does not exceed 30 days.

e. None. Health care providers without a license or other authorizing document, or who are for other reasons not appointed to the medical staff.

20. Revocation of Privileges. An adverse privileging action taken under reference (d) by a privileging authority which permanently removes all of a practitioner's clinical privileges. A revocation may be imposed by a privileging authority only after the opportunity for a peer review hearing has been afforded to the practitioner.

21. Supervision. The process of reviewing, observing, and accepting responsibility for the health care services provided by health care providers. Levels of supervision are defined as:

a. Indirect. The supervisor performs retrospective record review of selected records. Criteria used for review relate to quality of care, quality of documentation, and the member not exceeding the authorized scope of care.

b. Direct. The supervisor is involved in the decision-making process. This may be further subdivided as follows:

(1) Verbal. The supervisor is contacted by telephone or informal consultation before implementing or changing a regimen of care.

(2) Physically Present. The supervisor is physically present through all or a portion of care.

22. Suspension. An initial adverse action taken under reference (d) which temporarily removes all or a portion of a practitioner's clinical privileges. If only a portion of the practitioner's privileges are removed, it is a partial suspension. This summary action is imposed before the initiation of the peer review process.

23. Verification. Confirmation of the authenticity of health care provider credentials through contact with the issuing agency (the PSV) or use of a secondary source authorized by the Deputy Chief of Naval Operations (Manpower, Personnel, and Training) (MP&T) per references (l) through (o). Verification shall be documented.

ABBREVIATIONS

AAMFT	American Association of Marriage and Family Therapy
ABMS	American Board of Medical Specialty
ACGME	Accreditation Council for Graduate Medical Education
ACLS	Advanced Cardiac Life Support
ACSW	Academy of Certified Social Workers
ADDU	Additional Duty
ADSW	Active Duty for Special Work
ADT	Active Duty for Training
AFHPSP	Armed Forces Health Professions Scholarship Program
AFIP	Armed Forces Institute of Pathology
AFME	Armed Forces Medical Examiner
AIDS	Acquired immune deficiency syndrome
AMA	American Medical Association
ANCC	American Nurses Credentialing Center
APN	Advanced Practice Nurses
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASHA	American Speech Language Hearing Association
ASN(M&RA)	Assistant Secretary of the Navy for Manpower and Reserve Affairs
AT	Annual Training
ATLS	Advanced Trauma Life Support
Au.D	Doctor of Audiology
BSN	Bachelor of Science in Nursing
BUMED	Bureau of Medicine and Surgery
C-4	Combat Casualty Care Course
CCPD	Centralized Credentials Review and Privileging Detachment
CCQAS	Centralized Credentials and Quality Assurance System
CCU	Critical Care Unit
CDC	Centers for Disease Control
CO	Commanding Officer
COAMFTE	Commission on Accreditation for Marriage and Family Therapy Education
CQMP	Clinical Quality Management Program
CSWE	Council on Social Work Education
CTB	Credentials Transfer Brief
CVO	Credentials Verification Office

DDS	Doctor of Dental Surgery
DEA	Drug Enforcement Administration
DENBN	Dental Battalion
DMD	Doctor of Medical Dentistry
DO	Doctor of Osteopathy
DoD	Department of Defense
DON	Department of the Navy
DTF	Dental Treatment Facility
ECFMG	Educational Commission for Foreign Medical Graduates
ECODS	Executive Committee of the Dental Staff
ECOG	Electrocochleography
ECOMS	Executive Committee of the Medical Staff
EGD	Esophagogastroduodenostomy
ENOG	Electroneuronography
FAC(U)	Functional Area Code (U)
FMF	Fleet Marine Force
FMGEMS	Foreign Medical Graduate Examination of the Medical Sciences
FNLH	Foreign National Local Hire
FSSG	Force Service Support Group
FTOS	Full-Time Outservice
GME	Graduate Medical Education
HIV	Human Immunodeficiency Virus
HLTHCARE SUPPO	Health Care Support Office
HQMC	Headquarters of the Marine Corps
ICF	Individual Credentials File
ICTB	Inter-facility Credentials Transfer and Privileging Brief
ICU	Intensive Care Unit
IDTT	Inactive Duty Training Travel
IPF	Individual Professional File
IRR	Individual Ready Reserve
JAGMAN	Judge Advocate General Manual
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MARDIV	Marine Division
MARFORLANT	Marine Corps Forces Atlantic
MARFORPAC	Marine Corps Forces Pacific
MAW	Marine Air Wing
MD	Doctor of Medicine
MEF	Marine Expeditionary Forces
MHS	Military Health System
MP&T	Manpower, Personnel, and Training
MRO	Medical Review Officer

MSW	Master of Social Work
MTF	Medical Treatment Facility
NADDS	Navy Active Duty Delay Specialists
NCCPA	National Commission on Certification of Physician Assistants
NOTAL	Not to all
NPDB	National Practitioner Data Bank
NRC	Nuclear Regulatory Commission
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs
OIC	Officer in Charge
PA	Privileging Authority
PAC	Professional Affairs Coordinator
PAP	Papanicolaou, G.
PAR	Performance Appraisal Report
PAS	Privacy Act Statement
PCS	Permanent Change of Station
PhD	Doctor of Philosophy
PPIS	Personal and Professional Information Sheet
PRD	Projected Rotation Date
PSV	Primary Source Verification
RAD	Release from Active Duty
RDH	Registered Dental Hygienist
REDCOMS	Reserve Readiness Commands
SSN	Social Security Number
TAD	Temporary Additional Duty
TMD	Tempomandibular Disorders
TTS	Through the scope
TYCOM	Type Command
UENMSE	Upper Extremity Neuromusculoskeletal Evaluator
USNDC	U.S. Navy Dental Commands
USUHS	Uniformed Services University of the Health Sciences